

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u>	
c. LENGTH OF STAY IN 1b <u>10 days</u>		d. STREET ADDRESS <u>10901 BORNEDALE BLVD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anthony</u> Middle <u>John</u> Last <u>Abel</u>		4. DATE OF DEATH Month <u>6</u> Day <u>23</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-25-09</u>
9. AGE (In years lost birthday) yrs. <u>50</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter - self</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jack Abel</u>		14. MOTHER'S MAIDEN NAME <u>Hilda Raines</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes Army 1942-1945</u>		16. SOCIAL SECURITY NO. <u>579-22-6225</u>	
INFORMANT <u>Patient per phone</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Tamponade Suspected</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>10 days</u> <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 13, 6</u> , 19 <u>60</u> , to <u>June 23</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>June 23</u> , 19 <u>60</u> , and that death occurred at <u>12:00 AM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stephen E. Fatten</u> M.D.		ADDRESS (Street, city or town, state) <u>8641-Lochmill Road Silver Spring Md</u>	
DATE SIGNED <u>6/23/60</u>			
PHYSICIAN'S NAME (Type) <u>STEPHEN E. FATTEN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/28/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co. Washington, D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 27 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

74

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G264 6-10-60 et

CERTIFICATE OF DEATH

06998

Reg. Dist. No.

2019

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1402 Dilston Road</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 16</u> d. STREET ADDRESS <u>1402 Dilston Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>BESSIE</u> Middle <u>ABRAHAM</u> Last 5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>MAR. 15, 1900</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years lost birthday) <u>60</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.				4. DATE OF DEATH Month <u>JUNE</u> Day <u>6</u> Year <u>1960</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> 11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>NATHAN BANNER</u> 14. MOTHER'S MAIDEN NAME <u>EVA. — —</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u>—</u> INFORMANT (SON) <u>NORMAN ABRAHAM</u> Address <u>1020-QUEBEC TERR. S. S. MD.</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Gall Bladder</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>1551</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary Heart Disease.</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Dec. 1, 1959</u> to <u>June 6, 1960</u> that I last saw the deceased alive on <u>June 2, 1960</u> and that death occurred at <u>9:30</u> M. from the causes and on the date stated above. ACTUAL SIGNATURE <u>William S. Miller</u> M.D. <u>1835 Eye St. N.W.</u> DATE SIGNED <u>Wash D.C.</u> PHYSICIAN'S NAME (Type) <u>William S. Miller</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-7-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ELESAVETGRAD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON - D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. DANZANSKY & SONS - 3501-14th St. N.W.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>JUN 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knaus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7091

CERTIFICATE OF DEATH

66999

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Mont.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Laytonsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery General Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Adelia Middle M. Last Alinutt				4. DATE OF DEATH Month June Day 10 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 23, 1878	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 81 Days 81 Hours 81 Min. 81		IF UNDER 24 HRS. Months 81 Days 81 Hours 81 Min. 81			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Housework		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Aden D. Alinutt				14. MOTHER'S MAIDEN NAME Martha Virginia Duvall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Address Mrs. Mollie M. Childs-Derwood, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema 4-22-2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic myocarditis DUE TO (c) 10 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 19 55 to June 19 60 , that (I) (we) last saw the deceased alive on June 10 19 60 , and that death occurred at 11:40 A.M. from the causes and on the date stated above.							
22a. SIGNATURE A. D. Bonifant				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) A. D. BONIFANT				22d. ADDRESS Sandy Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-13-60		23c. NAME OF CEMETERY OR CREMATORY Laytonsville Meth.		23d. LOCATION (City, town, or county) (State) Laytonsville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber				ADDRESS Laytonsville, Md.		25a. REC'D BY REGISTRAR DATE JUN 14 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Travis			

19430 NO 7 ADVERTISED

1905



CHIEF OF BUREAU

Note: Montgomery County Medical Examiner Dr. Broschart notified and will approve.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
7020 Item 9		07000							
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Iowa b. COUNTY Winnescheik				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Decorah, Iowa				
c. LENGTH OF STAY IN 1b 8 months					d. STREET ADDRESS RFD # 4				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2208 Osborn Drive					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last ELLA GERTRUDE AMUNDSON					4. DATE OF DEATH Month Day Year JUNE 11 1960				
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 13, 1895		9. AGE (In years last birthday) 65 64 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Peter Olie Helgeson					14. MOTHER'S MAIDEN NAME Nellie Bagne				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) --		17. INFORMANT E. L. Overholt, Lt. Col., USA(MC)		Address Same as # 1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 9 - 1960 to June 11, 1960 , that (I) (we) lost the deceased alive on June 11, 1960 and that death occurred at 9:35 A.M. from the causes and on the date stated above.									
22a. SIGNATURE Richard L. Hench					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED June 11, 1960	
22c. PHYSICIAN'S NAME (Type) Richard L. Hench					22d. ADDRESS Staff, Walter Reed General Hosp. Washington 12, D. C.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 6/16/60		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county) (State) Decorah, Iowa	
24. FUNERAL DIRECTOR'S SIGNATURE Rinaldi Funeral Home, Inc.					ADDRESS 816 H St., NE, Wash. 2, DC		25a. REC'D BY REGISTRAR JUN 14 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna



1050

THE STATE OF TEXAS

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "STATE OF TEXAS" and "COUNTY OF" are visible.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

07001

7045

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mont</u> Middle <u>Clyde</u> Last <u>Andrews</u>				4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>1960</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-8-74</u>	9. AGE (In years lost birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - U.S. Govt.</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Steven Andrews</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Etelman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>medical Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral edema</u> 443X DUE TO (b) <u>Hypertensive Heart disease & failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Gout</u> INTERVAL BETWEEN ONSET AND DEATH <u>acute</u> <u>old</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June</u> , 19 <u>56</u> , to <u>June 3</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>June 3</u> , 19 <u>60</u> , and that death occurred at <u>9:45</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ernest A. Sarao</u> M.D.				ADDRESS (Street, city or town, state) <u>7006 N.H. Ave. TK-PK Md.</u> DATE SIGNED <u>6/3/60</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Ernest A. Sarao</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-6-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Southwesterly Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur L. Harris</u> ADDRESS <u>316 E. Diamond Baltimore Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

17

CERTIFICATE OF DEATH

7065

BRUCE
MILLEN

Name of deceased		Date of death	
Bruce Milles		July 10, 1965	
Age		Date of birth	
34		July 10, 1931	
Sex		Race	
Male		White	
Marital status		Cause of death	
Married		Heart disease	
Occupation		Place of death	
Teacher		Home	
Usual residence		Manner of death	
Baltimore, Md.		Natural	
Usual place of death		Physician's name	
Baltimore, Md.		Dr. J. H. Smith	
Signature of physician		Signature of registrar	
J. H. Smith		[Signature]	
Date of registration		Place of registration	
July 10, 1965		Baltimore, Md.	
Registrar's name		Registrar's title	
[Signature]		Registrar	
Date of filing		Place of filing	
July 10, 1965		Baltimore, Md.	
Filing officer's name		Filing officer's title	
[Signature]		Filing officer	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7092

CERTIFICATE OF DEATH

07002

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Northumberland</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>10 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reedville</u> <u>83X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>Box 44</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lenora</u> Middle <u>Edwards</u> Last <u>Balderson</u>				4. DATE OF DEATH Month <u>June</u> Day <u>18</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 22, 1904</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Registered Nurse</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Lemuel Edwards Megill</u>				14. MOTHER'S MAIDEN NAME <u>Mary Page</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>None</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Right hemothorax and chronic atelectasis, right lung</u> INTERVAL BETWEEN ONSET AND DEATH <u>Months</u> DUE TO <u>right pleura, and pericardium</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Disseminated metastatic carcinoma, peritoneum, left breast</u> <u>Months</u> DUE TO (c) <u>Healed bilateral mastectomy scars for carcinoma of</u> <u>10 Years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bilateral ovariectomy, hysterectomy, and pituitary stalk section-1 year</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> -NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>June 8</u> 19 <u>60</u> to <u>June 18</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>June 18</u> 19 <u>60</u> , and that death occurred at <u>2:15 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Paul J. Schwab</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>6/19/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>PAUL J. SCHWAB, M.D.</u>				22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>			
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>6/22/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rockland</u>		23d. LOCATION (City, town, or county) (State) <u>Reedville Va</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u>				ADDRESS <u>300 - 4th St NW</u>		25a. REC'D BY REGISTRAR <u>June 22 '60</u>	
				25b. REGISTRAR'S SIGNATURE <u>Robert L. Howard</u>			

MAINTAINING THE RECORDS OF DEATHS

NAME OF DECEASED: _____

AGE: _____

SEX: _____

DATE OF BIRTH: _____

DATE OF DEATH: _____

PLACE OF BIRTH: _____

PLACE OF DEATH: _____

Cause of Death: _____

Signature of Registrar: _____

Signature of Medical Officer: _____

Signature of Coroner: _____

Signature of Minister: _____

Signature of Clerk: _____

Signature of Nurse: _____

Signature of Doctor: _____

Signature of Pharmacist: _____

Signature of Dentist: _____

Signature of Veterinarian: _____

Signature of Engineer: _____

Signature of Surveyor: _____

Signature of Architect: _____

Signature of Painter: _____

Signature of Carpenter: _____

Signature of Joiner: _____

Signature of Blacksmith: _____

Signature of Saddler: _____

Signature of Shoemaker: _____

Signature of Tailor: _____

Signature of Hatter: _____

Signature of Druggist: _____

Signature of Apothecary: _____

Signature of Chemist: _____

Signature of Optician: _____

Signature of Jeweler: _____

Signature of Goldsmith: _____

Signature of Silversmith: _____

Signature of Watchmaker: _____

Signature of Clockmaker: _____

Signature of Instrument Maker: _____

Signature of Bookbinder: _____

Signature of Stationer: _____

Signature of Printer: _____

Signature of Bookkeeper: _____

Signature of Accountant: _____

Signature of Lawyer: _____

Signature of Judge: _____

Signature of Magistrate: _____

Signature of Justice of the Peace: _____

Signature of Mayor: _____

Signature of Town Clerk: _____

Signature of Schoolmaster: _____

Signature of Minister of the Gospel: _____

Signature of Chaplain: _____

Signature of Sexton: _____

Signature of Organist: _____

Signature of Choirman: _____

Signature of Vestryman: _____

Signature of Deacon: _____

Signature of Elder: _____

Signature of Brother: _____

Signature of Sister: _____

Signature of Friend: _____

Signature of Neighbor: _____

Signature of Acquaintance: _____

Signature of Stranger: _____

Signature of Unknown: _____

CHIEF CLERK

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7068 CERTIFICATE OF DEATH 07003

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4800 Montgomery Avenue		d. STREET ADDRESS 4800 Montgomery Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Channell Last Barker		4. DATE OF DEATH Month June Day 28 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/29/1881
9. AGE (In years last birthday) yrs. 78		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Channell		14. MOTHER'S MAIDEN NAME Sophia Somers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Betty Barker Reed		Address Wash. DC 6674 32nd Street, N.W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture, abdominal aorta 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bone marrow exhaustion DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CARCINOMA LEFT BREAST		INTERVAL BETWEEN ONSET AND DEATH 3 hours 7 1/4 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JAN. 30, 1959 to JUNE 28, 1960 that (I) (we) last saw the deceased alive on JUNE 28, 1960 , and that death occurred at 12:45 PM , from the causes and on the date stated above.			
22a. SIGNATURE Robert G. Angle		22b. DATE SIGNED JUNE 28, 1960	
22c. PHYSICIAN'S NAME (Type) Robert G. Angle		22d. ADDRESS 5009 Del Ray Avenue, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/30/60	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Prince Georges County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. - 2901 14th St., N.W.		25a. REC'D BY REGISTRAR DATE JUN 29 '60	
ADDRESS Washington, D.C.		25b. REGISTRAR'S SIGNATURE Arthur L. Hines	

7062

RECEIVED OF DEATH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Keensington</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>36 Keensington</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2901 Jennings Rd</u>						d. STREET ADDRESS <u>1 2901 Jennings Rd</u>					
3. NAME OF DECEASED (Type or print) <u>Anthony Geo. Barnday</u>						4. DATE OF DEATH <u>June 11 1960</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-31-1910</u>		9. AGE (in years last birthday) <u>49</u> yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cab driver</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>James Cab Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Geo. Barnday</u>						14. MOTHER'S MAIDEN NAME <u>Sarah Andrews</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes WWII</u>						16. SOCIAL SECURITY NO. <u>231-07-4762</u>					
17. INFORMANT <u>Wanda Barnday (wife)</u>						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Broschert</u>						M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>6-11-60</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						22b. DATE THEREOF <u>June 14, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or country) (State) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR <u>W.W. Chambers Co.</u>						ADDRESS <u>3072 - M St. N.W.</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 14 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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7093

CERTIFICATE OF DEATH

Reg. Dist. No. 07005

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Alta Vista Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ROLLA KENT Beattie</u>		4. DATE OF DEATH <u>June 2 1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 14, 1875</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR: Months <u>4</u> Days <u>18</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plant Pathologist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GOV'T</u>	
11. BIRTHPLACE (State or foreign country) <u>?</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James A. Beattie</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Bontly?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Daughter</u>		18. ADDRESS <u>12121 Glen Mill Rd. Rockville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Int</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>C.V. accident</u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 19</u> to <u>June 2</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>June 1</u> , 19 <u>60</u> , and that death occurred at <u>9:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William H. Killay</u>		ADDRESS (Street, city or town, state) <u>9902 Counselman Rd.,</u>	
PHYSICIAN'S NAME (Type) <u>William H. Killay</u>		DATE SIGNED <u>June 2, 1960</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>6-3-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>		ADDRESS <u>Bethesda, Md.</u>	
24a. REC'D BY REGISTRAR <u>W. H. 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. House</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

X

17/1875

John Taylor

T. J. Taylor

17/1875

CERTIFICATE OF DEATH

Reg. Dist. No.

07066

7094

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Monty</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington Grove</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>07 Washington Grove</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>108 Grove Ave</u>				d. STREET ADDRESS <u>108 Grove Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Mabel Lillian Becraft</u> First Middle Last				4. DATE OF DEATH <u>June 13 1960</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 14 1893</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Charles E. Becraft</u>				14. MOTHER'S MAIDEN NAME <u>Katie B. Penn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Helen Bean (sister) Steen 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0 Acute cardiac failure</u> DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>End-arteritis (left leg)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2 weeks</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1950</u> to <u>6-13</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>6-13</u> , 19 <u>60</u> , and that death occurred at <u>3:50 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8 Russell Ave Gaithersburg, md</u> DATE SIGNED							
ACTUAL SIGNATURE <u>F.J. Broschatt</u>				M.D. <u>8 Russell Ave Gaithersburg, md</u>			
PHYSICIAN'S NAME (Type) <u>F.J. Broschatt</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6-16-60</u>		<u>Forest Oak</u>		<u>Gaithersburg md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert C. Jarman</u> ADDRESS <u>Gaithersburg, md</u>				24a. RECEIVED BY REGISTRAR DATE <u>JUN 15 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7069 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 8, 9 Film 0269 6-20-60 et

07007

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>monty</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>52 Cherry Chase</u>	
c. LENGTH OF STAY IN 1b <u>8 yrs</u>		d. STREET ADDRESS <u>7017 W. Greenvale Parkway</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7017 W. Greenvale Parkway</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Anthony Andrew Benevento</u>		4. DATE OF DEATH <u>June 9 1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 8, 1904</u>
9. AGE (in years last birthday) <u>55</u>		10. IF UNDER 1 YEAR Months <u>9</u> Days <u>1</u>	
11. IF UNDER 24 HRS. Hours <u>1</u> Min. <u>0</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Benevento</u>		14. MOTHER'S MAIDEN NAME <u>Antoinette Gentile</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Yes-Unknown</u>	
17. INFORMANT <u>Dolores Benevento</u>		Address <u>Itun 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420+1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>6-10-60</u>	
ACTUAL SIGNATURE <u>Frank J. Bluschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Bluschant</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/13/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	22d. LOCATION (City, town, or country) (State) <u>Silver Spring, Maryland</u>
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		24a. REC'D BY REGISTRAR <u>June 14 '60</u>	
Address <u>Bethesda, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Klaus</u>	

MEDICAL CERTIFICATION

FOR THE
DEPARTMENT OF HEALTH

(M)

LS

1

Robert M. Murphy, Secretary, Maryland Department of Health

Date of Report: 10/10/60

Report of: 10/10/60

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7095
CERTIFICATE OF DEATH

07008

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida b. COUNTY Volusia X			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 28 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seville 48X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS No street address		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lillie Middle Viola Last Bennett				4. DATE OF DEATH Month June Day 17 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 27, 1902	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months 58 Days 58 Hours 58 Min. 58		IF UNDER 24 HRS. Months 58 Days 58 Hours 58 Min. 58			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Florida	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Edward Rossie				14. MOTHER'S MAIDEN NAME Surena Henry			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 263-48-4676		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Post operative status: Total pelvic exenteration DUE TO (c) Epidermoid carcinoma of the cervix INTERVAL BETWEEN ONSET AND DEATH 1 hour 8 days 11 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month May Day 20 Year 1960 Hour 11 o. m. 15 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Seville				20g. (County) Volusia		20h. (State) Florida	
21. I certify that (I) (this hospital) attended the deceased from May 20, 1960 to June 17, 1960 , that (I) (we) last saw the deceased alive on June 17, 1960 , and that death occurred at 1:15 AM from the causes and on the date stated above.							
22a. SIGNATURE Edward D. McLaughlin				22b. DATE 6/18/60		22c. PHYSICIAN'S NAME (Type) Edward D. McLaughlin, M.D.	
22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.				22e. REC'D BY REGISTRAR Arthur L. Kraus		22f. REGISTRAR'S SIGNATURE Arthur L. Kraus	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 6-19-60				23b. DATE THEREOF 6-19-60		23c. NAME OF CEMETERY OR CREMATORY Seville Cemetery	
23d. LOCATION (City, town, or county) Volusia County, Florida				23e. DATE JUN 21 '60		23f. REGISTRAR'S SIGNATURE Arthur L. Kraus	

CERTIFICATE OF DEATH

1932

State of Florida

County of Volusia

City of Orlando

Deceased

Age

Sex

Color

Occupation

Married

Signature

Witness

Minister

Funeral

Interment

Remarks

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7021

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 40 Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2809 Dennis Ave.				d. STREET ADDRESS 2809 Dennis Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Leonard M. Biggs, Sr.				4. DATE OF DEATH June 9 1960			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/10/83	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocery store				10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry M. Biggs				14. MOTHER'S MAIDEN NAME Alice L.W. Bremerman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. INFORMANT Leonard M. Biggs, Jr. same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure DUE TO Chronic Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 10 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 4 , 19 60 , to June 9 , 19 60 , that I last saw the deceased alive on June 9 , 19 60 , and that death occurred at 1 p.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 11800 Gsa Ave ss Md DATE SIGNED June 9, 1960							
ACTUAL SIGNATURE M. F. OTTMAN				M.D. 11800 Gsa Ave ss Md			
PHYSICIAN'S NAME (Type) M. F. OTTMAN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/11/60		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. Washington, 9, D.C.				24a. REC'D BY REGISTRAR DATE JUN 13 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Christina Margaret Brown
Christina Margaret Brown

THE OTTAWA
J. H. BROWN
11800
1911
J. H. BROWN
11800

CERTIFICATE OF DEATH

Reg. Dist. No.

07010

7022

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTG.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRG.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X SILVER SPRING</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4104 / SBELL ST.</u>		d. STREET ADDRESS <u>1 4104 / SBELL ST</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MAX</u> Middle <u>-</u> Last <u>BLASER</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>10</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL-8-1884</u> 16 yrs.
9. AGE (In years) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ACCOUNTANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	11. BIRTHPLACE (State or foreign country) <u>CZECHOSLOVAKIA</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>NOAH BLASER</u>	
14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>-</u>	
16. SOCIAL SECURITY NO. <u>178-05-2157</u>		INFORMANT Address <u>LILLIE BLASER 4104 / SBELL ST</u> <u>SSA</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of colon & rectum</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>60</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5-3</u> , 19 <u>60</u> , to <u>6-10</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>6-7</u> , 19 <u>60</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Abraham W. Danish</u> M.D.		ADDRESS (Street, city or town, state) <u>927 Rushing Rd Silver Spring, Md</u> DATE SIGNED <u>6-10-60</u>	
PHYSICIAN'S NAME (Type) <u>ABRAHAM W. DANISH</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	
22b. DATE THEREOF <u>6/2/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>NATL. MEM. PARK</u>	
22d. LOCATION (City, town, or county) (State) <u>FALLS CHURCH, VA.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Bedding Funeral Home</u> ADDRESS <u>4217-9th Xce</u>	
24a. REC'D BY REGISTRAR <u>JUN 13 60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEDICATION

1903



CERTIFICATE OF DEATH

Reg. Dist. No.

7096

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY Queens ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East Elmhurst 69X-3			
c. LENGTH OF STAY IN 1b 18 days				d. STREET ADDRESS 2441 Curtis Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Alfred Middle (none) Last Bonsignore, Jr.				4. DATE OF DEATH Month June Day 9 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 25, 1930	9. AGE (In years lost birthday) yrs. 30	IF UNDER 1 YEAR Months Days Hours Min. 	IF UNDER 24 HRS. Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alfred Bonsignore, Sr.				14. MOTHER'S MAIDEN NAME Pauline (Canassi ?)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unascertainable		INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure during operation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Rheumatic mitral insufficiency DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 10 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. 19 p. m. 	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from May 22 , 19 60 , to June 9 , 19 60 , that I last saw the deceased alive on June 9 , 19 60 , and that death occurred at 2:20 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) The Clinical Center DATE SIGNED 6/9/60 NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland							
ACTUAL SIGNATURE Roland Folsie		M.D. The Clinical Center 6/9/60 National Institutes of Health Bethesda 14, Maryland					
PHYSICIAN'S NAME (Type) Roland Folsie, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit 6/10/60	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY St. Raymonds Cemetery		22d. LOCATION (City, town, or county) (State) Bronx County, New York			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE JUN 13 '60	24b. REGISTRAR'S SIGNATURE Arthur L. Hanes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

County of Queens

City of New York

State of New York

City of New York

The undersigned, a duly qualified and licensed physician, do hereby certify that

On

the 10th day of

June

1900

at

the City of New York

State of New York

City of New York

at

the City of New York

State of New York

City of New York

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the City of New York

State of New York

City of New York

Robert A. Thompson, Bethesda, Maryland

at 4/10/00 St. Raymond's Cemetery, New York

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07012

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2202 Darrow Street		d. STREET ADDRESS 2202 Darrow Street	
3. NAME OF DECEASED (Type or print) Maurice Elmer Boren		4. DATE OF DEATH Month June Day 5 Year 19 60	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/23/1903
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Personal Dept.		10b. KIND OF BUSINESS OR INDUSTRY Dept. Store Woodward & Lothrop	
11. BIRTHPLACE (State or foreign country) Nebraska		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Maurice Elmer Boren		14. MOTHER'S MAIDEN NAME Mabel Bagg	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 506-18-6091	
17. INFORMANT Mary Margaret Boren--		Address 2202 Darrow St. Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 Hour			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Apr 1957 to June 5, 1960 , that (I) (we) last saw the deceased alive on June 5 1960 , and that death occurred at 3P M, from the causes and on the date stated above.			
22a. SIGNATURE John Lawrence Avery		22b. DATE SIGNED June 5 1960	
22c. PHYSICIAN'S NAME (Type) John Lawrence Avery		22d. ADDRESS 10110 Georgia Ave., Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/8/1960	23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	23d. LOCATION (City, town, or county) (State) Montgomery County, Md.
24. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co.		25a. REC'D BY REGISTRAR 2901 14th St. N.W. Washington, D.C.	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines		DATE JUN 7 '60	

40

CERTIFICATE OF DEATH

Reg. Dist. No.

07013

7097

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Damascus</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>P.O. Box 23</u>			
3. NAME OF DECEASED (Type or print) <u>"B" CURT WILBERT BOWLES</u>				4. DATE OF DEATH Month <u>June</u> Day <u>2</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/1/60</u>		9. AGE (In years lost birthday) <u>0</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u>	IF UNDER 24 HRS. Hours <u>2</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert W. Bowles</u>				14. MOTHER'S MAIDEN NAME <u>Delores Elyard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		INFORMANT Address <u>Delores E. Bowles (same as above)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO <u>780.5</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>immaturity + prematurity</u> DUE TO (c) <u>Intraventricular hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>6/1/60</u> , 19 <u>60</u> , to <u>6/2/60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>6/2/60</u> , 19 <u>60</u> , and that death occurred at <u>7:20 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Vincent L. O'Donnell</u>				ADDRESS (Street, city or town, state) <u>8218 Wisconsin Ave. Bethesda, Md</u>			
PHYSICIAN'S NAME (Type) <u>Vincent L O'Donnell</u>				DATE SIGNED <u>6/2/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/7/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 8 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneiss</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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De la part de l'Université

7098

CERTIFICATE OF DEATH

07014

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
c. LENGTH OF STAY IN 1b 3 days				d. STREET ADDRESS 3817 22nd. St. N.E.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ch ester Middle Orville Last Bradley				4. DATE OF DEATH Month June Day 13 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/18/01	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months 58 Days 13 Hours 19 Min.		IF UNDER 24 HRS. Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) G lazier				10b. KIND OF BUSINESS OR INDUSTRY Circle Glass Co.		11. BIRTHPLACE (State or foreign country) Wash. D.C	
12. CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME Georg e A. Bradley				14. MOTHER'S MAIDEN NAME Nettie Landon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. yes-Unknown			
INFORMANT M rs. Virginia Bradley Wife)				Address Same as Above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bilateral ureteral Obstruction DUE TO (c) Metastatic Carcinoma (Primary in Colon)						INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from March 28, 1959 , to June 13, 1960 , that I last saw the deceased alive on June 13, 1960 , and that death occurred at 12:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE John E. Ball				ADDRESS (Street, city or town, state) DATE SIGNED Old Georgetown Rd. Beth. Md 6/13/60			
PHYSICIAN'S NAME (Type) John Ball							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/17/60		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE JUN 16 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7099

CERTIFICATE OF DEATH

Item 9 Film 6265 6-23-60 et

07015

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 125 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE North Dakota b. COUNTY Grand Forks c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grand Forks d. STREET ADDRESS 1507 North Fourth Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Leroy Harold Bratlie		4. DATE OF DEATH Month Day Year June 13 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 4, 1931
9. AGE (In years last birthday) yrs. 29		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		11b. KIND OF BUSINESS OR INDUSTRY Fire Company	
11c. BIRTHPLACE (State or foreign country) North Dakota		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ruben Bratlie		14. MOTHER'S MAIDEN NAME Iva Gorde	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Unascertainable	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Intracerebral hemorrhage (c) Aplastic anemia		INTERVAL BETWEEN ONSET AND DEATH minutes 2 days 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from February 2, 1960 to June 13, 1960 , that (I) (we) last saw the deceased alive on June 13, 1960 , and that death occurred at 11:15pm from the causes and on the date stated above.			
22a. SIGNATURE Norman R. Gevitz M.D.		22b. DATE SIGNED 6/14/60	
22c. PHYSICIAN'S NAME (Type) Norman R. Gevitz, M.D.		22d. ADDRESS The Clinical Center Maryland National Institutes of Health, Bethesda 14,	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 6-15-60		23b. DATE THEREOF 6-15-60	
23c. NAME OF CEMETERY OR CREMATORY Bethany Cemetery		23d. LOCATION (City, town, or county) (State) Grand Forks County, N. D.	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		25a. REC'D BY REGISTRAR DATE JUN 20 '60	
25b. REGISTRAR'S SIGNATURE Carlton S. House			

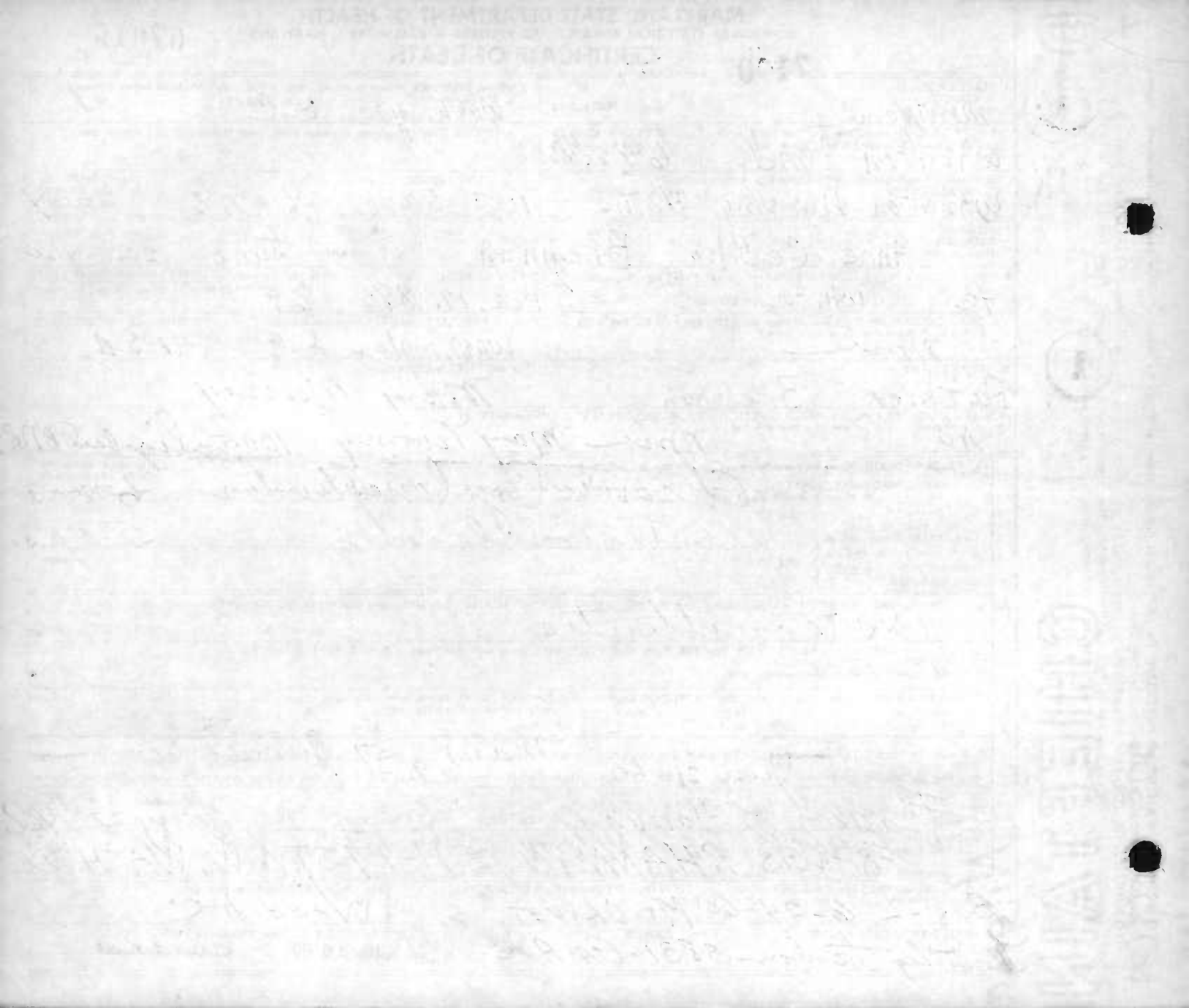
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7100
CERTIFICATE OF DEATH

07016

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington D.C.</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton, Md.</u>		c. LENGTH OF STAY IN 1b <u>6 weeks</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wheaton Nursing Home</u>		d. STREET ADDRESS <u>1005 Sigsbee Pl., N.E.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Anne Cecilia Brennan</u>		4. DATE OF DEATH Month Day Year <u>June 22 1960</u>	
5. SEX <u>fe</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 17, 1890</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Patrick Brennan</u>		14. MOTHER'S MAIDEN NAME <u>Mary Murray</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mary Twomey - 1005 Sigsbee Pl. N.E.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Pyelonephritis</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u> <u>5 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Osteoarthritis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 1, 1957</u> to <u>June 23, 1960</u> that (I) (we) last saw the deceased alive on <u>June 21, 1960</u> and that death occurred at <u>9:00 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Francis P. Hannan</u> M.D.		22b. DATE SIGNED <u>June 22, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANCIS P. HANNAN</u>		22d. ADDRESS <u>1511-17 ST. N.W., WASH. D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6-24-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. OLIVET</u>		23d. LOCATION (City, town, or county) (State) <u>WASH. D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy Haulon</u> ADDRESS <u>3831-GA. AVE.</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 30 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7024

CERTIFICATE OF DEATH

07017

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 3 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3006 Dawson Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CLARK Middle FERGUSON Last BROWN		4. DATE OF DEATH Month June Day 20 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/13/88
9. AGE (in years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supply Clerk (retired)		10b. KIND OF BUSINESS OR INDUSTRY U.S. Naval Gun Factory	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PERRY FRANKLIN BROWN		14. MOTHER'S MAIDEN NAME MARGARET BAKER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) NONE	
17. INFORMANT Mr. Carl D. Crist, 3006 Dawson Ave.		Address Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Myocardial Infarction Coronary Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH none 4 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from Oct. 30, 1956 to June 20, 1960 that (I) (the hospital) saw the deceased alive on June 18, 1960 and that death occurred at 4:45 PM from the causes and on the date stated above.			
22a. SIGNATURE M. van Kinsbergen		22b. DATE SIGNED June 20, 1960	
22c. PHYSICIAN'S NAME (Type) M. van Kinsbergen		22d. ADDRESS 29 Grant Circle, N.W., Washington, D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/24/60	
23c. NAME OF CEMETERY OR CREMATORY BROOKEVILLE CEMETERY		23d. LOCATION (City, town, or county) (State) BROOKEVILLE, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Pumphrey, Inc.		25a. REC'D BY REGISTRAR DATE JUN 27 '60	
ADDRESS SILVER SPRING, MD.		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

37

June 30 1900

Government of the United States
Department of the Interior

June 30 1900

W. H. H. H.

CERTIFICATE OF DEATH

Reg. Dist. No.

7046

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>6 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>			d. STREET ADDRESS <u>8308 Greenwood Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Loretta</u> Middle <u>Jean</u> Last <u>Brummett</u>			4. DATE OF DEATH Month <u>June</u> Day <u>24</u> Year <u>1960</u>		
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 19, 1960</u>		9. AGE (In years last birthday) yrs. <u>6</u> Months <u>11</u> Days <u>11</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>newborn</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>			13. FATHER'S NAME <u>Henry Allen Brummett</u>		
14. MOTHER'S MAIDEN NAME <u>Alice Jean Brown</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		
16. SOCIAL SECURITY NO.			17. INFORMANT <u>mother</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>prematurity, cardio vascular</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>collapse, septicemia</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____					
21. I certify that I attended the deceased from <u>June 19, 1960</u> , to <u>June 24, 1960</u> , that I last saw the deceased alive on <u>June 24, 1960</u> , and that death occurred at <u>12:50pM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Marvin I. Mones</u> M.D.		ADDRESS (Street, city or town, state) <u>927 Pershing Dr. S S</u>			
PHYSICIAN'S NAME (Type) <u>Marvin I. Mones, M.D.</u>		DATE SIGNED <u>927 Pershing Drive, Silver Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		22b. DATE THEREOF <u>6-28-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington Sanitarium & Hosp. Takoma Park Md.</u>	
22d. LOCATION (City, town, or county) _____ (State) _____					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Hare, M.D., Washington Sanitarium & Hosp</u>		ADDRESS <u>Washington Sanitarium & Hosp</u>		24a. REC'D BY REGISTRAR <u>DATE Jul 6 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2075403XV4

7101

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Browningsville		c. LENGTH OF STAY IN 1b Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD #1, Monrovia		d. STREET ADDRESS RFD #1, Monrovia	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Willie Middle H. Last Burdette		4. DATE OF DEATH Month June Day 30 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 5, 1866
9. AGE (In years lost birthday) 93 yrs.		IF UNDER 1 YEAR Months 93 Days 93 Hours 93 Min. 93	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Hyattstown, Md.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John E. Burdette		14. MOTHER'S MAIDEN NAME Mary E. Watkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
INFORMANT Mr. Milton W. Burdette, Monrovia, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 422.1 DUE TO (c) 15 years		INTERVAL BETWEEN ONSET AND DEATH 15 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/15 , 19 54 , to 6/30 , 19 60 , that I last saw the deceased alive on 6/29 , 19 60 , and that death occurred at 11:40 a. m. from the causes and on the date stated above.			
ACTUAL SIGNATURE James P. Kerr		ADDRESS (Street, city or town, State) Damascus, Md.	
PHYSICIAN'S NAME (Type) James P. Kerr		DATE SIGNED 7/1/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 2, 1960	
22c. NAME OF CEMETERY OR CREMATORY Bethesda Methodist		22d. LOCATION (City, town, or county) (State) Browningsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Mohamath		ADDRESS Damascus, Md.	
24a. REC'D BY REGISTRAR JUL 5 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1901

NAME OF DECEASED

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

TIME OF DEATH

AGE OF DECEASED

SEX OF DECEASED

EDUCATION

OCCUPATION

RELIGION

ETHNIC ORIGIN

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

TIME OF DEATH

AGE OF DECEASED

SEX OF DECEASED

EDUCATION

OCCUPATION

RELIGION

ETHNIC ORIGIN

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

TIME OF DEATH

AGE OF DECEASED

SEX OF DECEASED

EDUCATION

OCCUPATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7025
CERTIFICATE OF DEATH

07020

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington, DC	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, DC	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1800 Grace Church Rd.		d. STREET ADDRESS 1724 Newton St NW	
3. NAME OF DECEASED (Type or print) First Sarah Middle E Last Byrne		4. DATE OF DEATH Month June Day 15 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH July 19, 1868
9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR Months 6 Days 15 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Leonidas Jones		14. MOTHER'S MAIDEN NAME Elizabeth King	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Mrs Pauline Cissel		Address 1519 Monroe St NW, DC	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410X Congestive heart failure DUE TO (b) Myocardial Stenosis DUE TO (c) Chronic sclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary edema - uremic poisoning		INTERVAL BETWEEN ONSET AND DEATH 6 mos 5 yrs 10 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Jan Day 27 Year 1960 Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 27, 1960 to June 15, 1960 , that (I) (we) last saw the deceased alive on June 15, 1960 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE J.E. Virnstein		22b. DATE SIGNED 6/15/60	
22c. PHYSICIAN'S NAME (Type) J.E. VIRNSTEIN		22d. ADDRESS 3311-16 H.W. Wash. 10. DC	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/18/60	
23c. NAME OF CEMETERY OR CREMATORY Monocacy Cemetery		23d. LOCATION (City, town, or county) (State) Beallsville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. Washington, D. C.		25a. REC'D BY REGISTRAR JUN 17 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Hines			

CERTIFICATE OF DEATH

1935



Washington, DC

Elmer George

1900 George Street N.E.

1212 Madison St N.E.

White

Male

July 19, 1900

Female

Married

Married

Married

Married

The having signed a statement to the effect

that the deceased

Elmer George
Washington, D.C.
July 19, 1900
Married
White
Male
1900 George Street N.E.
1212 Madison St N.E.
Washington, DC

3311-15 5th Street N.E.
6/2/35

Elmer George
Washington, D.C.
July 19, 1900
Married
White
Male
1900 George Street N.E.
1212 Madison St N.E.
Washington, DC

The S. E. Hines Co. Washington, D. C.
1935-1936

7102

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>14508-Windsor Lane</u>	
3. NAME OF DECEASED (Type or print) First <u>Ernest F.</u> Middle <u>Callahan</u> Last <u></u>		4. DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 5, 1890</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>9</u> Days <u>5</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>InterState Commerce</u> <u>Ind.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Patrick Callahan</u>		14. MOTHER'S MAIDEN NAME <u>Anna Shaffer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes.</u> (If yes, give war or dates of service) <u>Army World War II</u>		16. SOCIAL SECURITY NO. <u>no.</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 Hrs</u> <u>5 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>50</u> , to <u>Jun</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>June 11</u> , 19 <u>60</u> , and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS (Street, city or town, state) <u>8218 WISC AVE</u> DATE SIGNED <u>6/13/60</u>	
PHYSICIAN'S NAME (Type) <u>LEO I DOWDAN MD</u>		<u>Bethesda 14 Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/17/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	24a. REC'D BY REGISTRAR <u>DATE JUN 16 '60</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1991

So

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 13 days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Isaiahburg

d. STREET ADDRESS Route #2 Emory Grove Rd

3. NAME OF DECEASED (Type or print) First Middle Last GEORGE BENNETT CAMPBELL 4. DATE OF DEATH JUNE 29 1960

5. SEX MALE 6. COLOR OR RACE W 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH 6/16/60 9. AGE (In years last birthday) yrs. 13 IF UNDER 1 YEAR Months 13 Days 13 Hours 13 Min. 13

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) — 10b. KIND OF BUSINESS OR INDUSTRY — 11. BIRTHPLACE (State or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME NOT GIVEN 14. MOTHER'S MAIDEN NAME DORIS ELAINE CAMPBELL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — 16. SOCIAL SECURITY NO. — INFORMANT MOTHER Address —

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure
773.3 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Immaturity DUE TO
(c) Immaturity

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6/17/60, 1960, to 6/29/60, 1960, that I last saw the deceased alive on 6/28/60, 1960, and that death occurred at 3:20 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE Vincent L. O'Donnell M.D. 8218-Wisc Ave Beth Md DATE SIGNED 6/30/60

PHYSICIAN'S NAME (Type) —

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 7-2-60 22c. NAME OF CEMETERY OR CREMATORY Brookside Grove 22d. LOCATION (City, town, or county) (State) Laytonsville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE Robert C. Newden ADDRESS Rockville Md 24a. REC'D BY REGISTRAR — DATE JUL 6 '60 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

(15)

[Faint, mostly illegible handwritten text, possibly a letter or report, covering the majority of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

17023

7047

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital				d. STREET ADDRESS 1325 Grandin Avenue			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last (baby) Carle				4. DATE OF DEATH Month Day Year June 13 19 60			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 11, 1960	
9. AGE (In years last birthday) 36		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) baby		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Michael Theodore Carle				14. MOTHER'S MAIDEN NAME Jacqueline Trik Monroe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. Mother			
17. INFORMANT Mother				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARNOLD-CHIARI DEFECT 752X DUE TO HYDROCEPHALUS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) AT BIRTH DUE TO (c) AT BIRTH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DILATATION OF RIGHT ATRIUM							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Takoma Park				20g. (County) Md.		20h. (State) Md.	
21. I certify that I attended the deceased from 12:55pm June 13 60 to 1:10pm June 13 60 , that I last saw the deceased alive on June 13 19 60 , and that death occurred at 1:10pm , from the causes and on the date stated above.							
ACTUAL SIGNATURE Ira W. Pearlman				DATE SIGNED JULY 5, 1960			
PHYSICIAN'S NAME (Type) Ira W. Pearlman, M.D., 4700 Bradley Blvd., Chevy Chase, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 6-27-60		22c. NAME OF CEMETERY OR CREMATORY Washington San & Hosp.		22d. LOCATION (City, town, or county) (State) Takoma Park Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Hare, M.D., Washington San & Hosp.				24a. REC'D BY REGISTRAR DATE JUL 11 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

7104

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 6 days 10 Hrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 905 Baltimore Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Earl S Carter				4. DATE OF DEATH Month June Day 16 Year 1960			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/10/07	9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months 6 Days 6 Hours Min. 	IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Mont. County Board of Education		11. BIRTHPLACE (State or foreign country) Gaithersburg, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elliott Carter				14. MOTHER'S MAIDEN NAME Lula Selby			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-03-6959		INFORMANT Mrs. Edna M. C arter Address 905 Baltimore Rd. Rockville			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Right Coronary Thrombosis DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Thrombosis DUE TO Generalized Arteriosclerosis (c) 							INTERVAL BETWEEN ONSET AND DEATH 4 days 6 days Indef.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 6 - 9 , 19 60 , to 6 - 16 , 19 60 , that I last saw the deceased alive on June 16 , 19 60 , and that death occurred at 6:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8218 Wisconsin Ave 1 DATE SIGNED 6-16-60							
ACTUAL SIGNATURE Francis C. Mayle Jr				M.D. Bethesda Md			
PHYSICIAN'S NAME (Type) FRANCIS C. MAYLE JR							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/20/60		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR JUN 20 60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7104



11

CENTRAL OF CALIF

Robert J. Thompson, Bethesda, Maryland
National Academy of Sciences
January 1, 1954

7048
CERTIFICATE OF DEATH07025
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAROMA PARK	c. LENGTH OF STAY IN 1b 10 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) W. HYATTSVILLE 1656-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 517 ALBANY AVE. (OAK HAVEN)		d. STREET ADDRESS 8108-14TH AVE.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) CAROLINA First Middle Last CATANIA		4. DATE OF DEATH Month JUNE Day 16 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 12, 1877
9. AGE (In years lost birthday) yrs. 83		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ITALY	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			

13. FATHER'S NAME ANTHONY VILARDO		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. YES	
INFORMANT KATE DI PASQUA-8108-14TH AVE.		Address WEST HYATTS, MD.	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 296.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Anemia DUE TO (c) Malnutrition		INTERVAL BETWEEN ONSET AND DEATH 1 day unknown unknown
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--	--------------------------------------------------------------------------------------

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/5 , 19 59 , to 6/16 , 19 60 , that I last saw the deceased alive on 6/16 , 19 60 , and that death occurred at 2 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 918 University Blvd. E., Silver Spring, Md.	DATE SIGNED 6/16/60
ACTUAL SIGNATURE EINO MAGI		M.D. 918 University Blvd. E., Silver Spring, Md.	
PHYSICIAN'S NAME (Type) EINO MAGI			

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 6-21-60	22c. NAME OF CEMETERY OR CREMATORY GATES OF HEAVEN CEM.	22d. LOCATION (City, town, or county) (State) WESTCHESTER CO. N.Y.C. N.Y.
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins		ADDRESS WASH. D.C.	24a. REC'D BY REGISTRAR JUN 20 '60
24b. REGISTRAR'S SIGNATURE Arthur L. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8295

04-15-93 14:00:00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7049

CERTIFICATE OF DEATH

07026

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>9 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>24</u>		d. STREET ADDRESS <u>711 Midhurst Rd.</u> <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanit Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MR. Alfred Randolph Clarke</u>		4. DATE OF DEATH Month <u>6</u> Day <u>30</u> Year <u>1960</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-22-83</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during last year of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>	
11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Alfred Clarke</u>		14. MOTHER'S MAIDEN NAME <u>Annie E. Wicker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEMORRHAGE, MASSIVE, POSTOPERATIVE, INTRAABDOMINAL</u> DUE TO <u>467</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>HOURS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NEPHROSITIS, CHRONIC, BILATERAL, WITH RIGHT STAGHORN CALCULUS</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12-58</u> to <u>6/30</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>6/30</u> 19 <u>60</u> , and that death occurred at <u>7:15</u> M, from the causes and on the date stated above.		22a. SIGNATURE <u>Dean H. Harding</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Dean H. Harding</u>		22d. ADDRESS <u>113 CARROLL ST. NW. WASH. DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/2/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S H Hines Co.</u> ADDRESS <u>2901-14th NW Washington DC</u>		25a. REC'D BY REGISTRAR <u>JUL 1 '60</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

(14)

(1)

(3)

1914

1915

1916

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please give the carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7105

CERTIFICATE OF DEATH

07027

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 64 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia		b. COUNTY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 202 Chapel Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Steele		Middle Simmons		Last CLARKE		4. DATE OF DEATH Month June		Day 21		Year 19 60	
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-8-20		9. AGE (In years lost birthday) yrs. 40		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) North Carolina				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Robert R. SIMMONS				14. MOTHER'S MAIDEN NAME Jessie STEELE							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 238-12-0757		17. INFORMANT (H) Robert A. Clarke, same as #2 above				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of breast - metastases DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 15 mos										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 60		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Suitland		(County) Maryland		(State)	
21. I certify that (I) physician attended the deceased from April 18 1960 to June 21 1960 , that (I) yes saw the deceased alive on June 21 1960 , and that death occurred at 6:50PM from the causes and on the date stated above.											
22a. SIGNATURE E. J. Rupnik				M.D. E. J. RUPNIK, CDR, MC, USN		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6-22-60			
22c. PHYSICIAN'S NAME (Type) E. J. RUPNIK, CDR, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 6-23-60		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City, town, or county) Suitland		(State) Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Jos. Gawler's & Sons, 1756 Pa. Ave., NW, WashDC						25a. REC'D BY REGISTRAR JUN 24 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

CENTRAL OF DEATH

1105

Virginia

Annals

of days

of days (New)

303 Chapel Drive

U. S. Naval Hospital

June 21 1900

CHANCE

Stanton

Greene

40

8-8-20

Chapman

Female

North Carolina

Marshall

Greene Street

Robert H. Kitchin

1900 to 1901 235-18-1917 (1) Robert A. Dixon, born on 18-19-1900

1900 to 1901

June 21 1900

1911 15

June 21 1900

U. S. Naval Hospital

U. S. Naval Hospital, 303, 304

Marshall

Greene

Greene Hill Cemetery

1900 to 1901

The Governor's House, 1725 E. Ave., Wash. D. C.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7106 **CERTIFICATE OF DEATH**

07028

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 143 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 804 Madison Avenue, N.W.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First WILLIAM Middle "C" Last COBBS				4. DATE OF DEATH Month June Day 18 Year 19 60			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-29-12	
9. AGE (In years lost birthday) 48 yrs.		IF UNDER 1 YEAR Months 4 Days 21		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor				10b. KIND OF BUSINESS OR INDUSTRY South Carolina		11. BIRTHPLACE (State or foreign country) U. S. A.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Wade COBBS				14. MOTHER'S MAIDEN NAME Essie LONG			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes				16. SOCIAL SECURITY NO. World War II 579-09-7683		17. INFORMANT Address Wash., D.C. (W) Mrs. Maud Cobbs, 735 New Jersey Ave., N.W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 201X DUE TO <div style="display: flex; align-items: center;"> <div style="font-size: 2em; margin-right: 10px;">}</div> <div> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. </div> </div> </p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that X (this hospital) attended the deceased from January 27, 1960 to June 18, 1960 , that X (we) last saw the deceased alive on 18 June 1960 , and that death occurred at 1:00 PM from the causes and on the date stated above.							
22a. SIGNATURE F. H. O'Connell				22b. DATE SIGNED 22 June 1960			
22c. PHYSICIAN'S NAME (Type) F. H. O'CONNELL, LCDR, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-23-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE W. E. Jarvis Funeral Home, Washington, D. C.				25a. REC'D BY REGISTRAR DATE JUN 21 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1901

8 . 2 . 0

U. S. GOVERNMENT PRINTING OFFICE: 1967

7107 CERTIFICATE OF DEATH

Reg. Dist. No.

07020

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Mont.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 8 hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Infant Girl Colie				4. DATE OF DEATH Month Day Year June 6 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 6, 1960	
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Bethesda, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Colie				14. MOTHER'S MAIDEN NAME Margaret Arnold			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) --				16. SOCIAL SECURITY NO. --			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fetal Alelectosis 762.5 DUE TO Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 8 hours (c) 8 hours				INTERVAL BETWEEN ONSET AND DEATH 8 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 6-6 , 19 60 to 6-6 , 19 60 that I last saw the deceased alive on 6-6 , 19 60 , and that death occurred at 11:30 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE J. W. Pearlman M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 6-9-60		22c. NAME OF CEMETERY OR CREMATORY Suburban Hospital		22d. LOCATION (City, town, or county) (State) 8600 Old Georgetown Rd Bethesda, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Suburban Hospital 8600 Old Georgetown Rd				24a. REC'D BY REGISTRAR DATE JUN 14 '60		24b. REGISTRAR'S SIGNATURE Arthur S. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11

MADE IN U.S.A.

MADE IN U.S.A.

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Place of birth: _____

6. Date of death: _____

7. Place of death: _____

8. Cause of death: _____

9. Signature of physician: _____

10. Signature of registrar: _____

11. Date of registration: _____

12. Place of registration: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7108

CERTIFICATE OF DEATH

07050

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN TB 2 hrs. 20 min. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Alexandria c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 83X-3 d. STREET ADDRESS 3742 Keller Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Thomas Middle William Last COLLINS		4. DATE OF DEATH Month June Day 15 Year 19 60				
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-6-18 1916	9. AGE (In years last birthday) 43 1/2 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Marine Corps		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William COLLINS			14. MOTHER'S MAIDEN NAME Katherine SHEAHAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1942 to DOD 579-24-0263		17. INFORMANT (W) Mrs. Margaret Collins, same as #2 above		Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Ventricular Fibrillation Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) myocardial infarct (c) Coronary Thrombosis Coronary atherosclerosis INTERVAL BETWEEN ONSET AND DEATH 5 minutes 3 hours 3 hours years +						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from June 15 1960 to June 15 1960 , that (I) (xx) lost the deceased alive on June 15 1960 , and that death occurred at 8P M, from the causes and on the date stated above.						
22a. SIGNATURE F. H. O'Connell		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6-16-60		
22c. PHYSICIAN'S NAME (Type) F. H. O'CONNELL, LCDR, MC, SSN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-20-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery Arlington Va.		23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers & Co., Inc.		ADDRESS 1400 Chapin St., NW, WashDC		25a. REC'D BY REGISTRAR JUN 20 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus

7103

CERTIFICATE OF DEATH

Virginia

County

Bechtel (Name)

2 yrs. 80 min. Alexandria

U. S. Naval Hospital

3700 Bell St.

Thomas

William

Collins

John

Occupation

12-8-18

Officer

U.S. Marine Corps

Washington, D. C.

U.S.A.

William Collins

Residence

Yes 1942 to 1945 (W) 1942 to 1945 (W) 1942 to 1945 (W) 1942 to 1945 (W)

Examiner

June 12

June 12

June 12

6-20-50

Washington National Cemetery

F. M. O'Connell, MD, USN U. S. Naval Hospital, Washington, DC.

W. W. Chambers & Co., 1400 Capital St., NW, Washington, D. C.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, Page 1, 2, and 3 to the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7050

07051

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN b 3 Weeks d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium & Hosp				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fairfax d. STREET ADDRESS 7 Colony Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Frank Chris Collis				4. DATE OF DEATH Month Day Year June 4 1960			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 5, 1919	
9. AGE (In years last birthday) 40 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Window Decorator		11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Chris Collis				14. MOTHER'S MAIDEN NAME Leona Dishman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Fracture Right Leg DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fell from stepladder							INTERVAL BETWEEN ONSET AND DEATH 6Hrs 3Weeks
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell from stepladder			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 12 Noon 5/15 19 60		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Embassy Men's Wear		20f. (City or town) (County) (State) Wash. D. C.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschart EXAMINER'S NAME (Type)				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 6/5/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/7/60		22c. NAME OF CEMETERY OR CREMATORY National Memorial Park		22d. LOCATION (City, town, or country) (State) Falls Church Va.	
23. FUNERAL DIRECTOR David H. Brandall ADDRESS Fairfax, Va.				24a. REC'D BY REGISTRAR DATE JUN 8 '60		24b. REGISTRAR'S SIGNATURE Arthur E. Hume	

MEDICAL CERTIFICATION



100-2411
100-2411

3050

UNITED STATES DEPARTMENT OF HEALTH
NATIONAL BUREAU OF HEALTH
STATISTICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of deceased: *John D. Smith*

2. Sex: *Male*

3. Age: *35*

4. Date of death: *Sept 2, 1944*

5. Place of death: *Home*

6. Cause of death: *Heart disease*

7. Manner of death: *Natural*

8. Signature of examiner: *John D. Smith*

9. Date of certificate: *Sept 2, 1944*

10. Office of health officer: *City of New York*

TO SUPPLY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any data is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07032

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Potomac		c. LENGTH OF STAY IN 1b 60	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10017 Chapel Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Potomac	
3. NAME OF DECEASED (Type or print) First GORDON Middle F. Last COOPER		4. DATE OF DEATH Month June Day 10 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 28, 1903
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months 57 Days 57 Hours 57 Min. 57	IF UNDER 24 HRS. Months 57 Days 57 Hours 57 Min. 57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY Telephone Co.	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME George Cooper		14. MOTHER'S MAIDEN NAME Cora Fox	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Yes-Unknown	
17. INFORMANT Wife		Address Mrs. Emily S. Cooper	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Found dead in Bed. (c) in Bed.		INTERVAL BETWEEN ONSET AND DEATH Found dead in Bed.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart		DATE SIGNED June 10, 1960	
EXAMINER'S NAME (Type) FRANK J. BROSCHART		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-13-60	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Prince George Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR DATE JUN 14 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraw	

60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07033

7110

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b 6 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BRINKLOW	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY Co. GENERAL HOS PITAL				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNIE Middle HARRISON Last COSTLEY			4. DATE OF DEATH Month JUNE Day 3 Year 1960				
5. SEX FEMALE	6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ? 1878		9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WILLIAM HARRISON				14. MOTHER'S MAIDEN NAME SALLY -- unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT HOSPITAL RECORDS OLNEY, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO Coronary sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary edema; Acute (c) Peptic ulcer; stomach							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1959 to June 1960 that (I) (we) last saw the deceased alive on June 3 1960 , and that death occurred 1:15 from the causes and on the date stated above.							
22a. SIGNATURE A. D. Bonifant				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) A. D. BONIFANT, M. D.				22d. ADDRESS SANDY SPRING, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6-6-1960		23c. NAME OF CEMETERY OR CREMATORY White Rock		23d. LOCATION (City, town, or county) (State) Carroll Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,				ADDRESS Winfield, Md.		25a. REC'D BY REGISTRAR DATE JUN 7 '60	
				25b. REGISTRAR'S SIGNATURE Arthur L. Frank			

CERTIFICATE OF DEATH

110

X

1978

Home

Housewife

UNKNOWN

None

NO

CARROLL CO., INC.

WHITE HOUSE

BURIAL 5-6-1900

WIND 10, NO.

O. M. WILK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7026

CERTIFICATE OF DEATH

Reg. Dist. No.

07034

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b 14 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 28 Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9507 WARREN ST				d. STREET ADDRESS 19507 WARREN ST		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROBERT Middle C. Last COURBAT				4. DATE OF DEATH Month JUNE Day 20 Year 19 60			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 4, 1890	
9. AGE (In years last birthday) 70		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman - Carpenter				10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't. Dept. of Interior		11. BIRTHPLACE (State or foreign country) SWITZERLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME ALPHONSE COURBAT				14. MOTHER'S MAIDEN NAME ANNA CHEVILLAT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 579-14-1491		17. INFORMANT Address Mrs. Nora M. Courbat, 9507 Warren St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4-20-60 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) 4 YRS INTERVAL BETWEEN ONSET AND DEATH 5 Min							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July , 19 57 , to 6-20 , 19 60 , that I last saw the deceased alive on 6-10 , 19 60 , and that death occurred at 5:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 915 19TH ST NW DATE SIGNED 6-20-60							
ACTUAL SIGNATURE Lewis H Biben M.D. 915 19TH ST NW							
PHYSICIAN'S NAME (Type) LEWIS H. BIBEN MD WASHINGTON DC							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/22/60		22c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY		22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE WALTER E. PUMPHREY, INC. Raymond A. Jaska				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE JUN 22 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Knap			

250

28

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

07035

7111

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 15 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL		d. STREET ADDRESS CLARKSVILLE	
3. NAME OF DECEASED (Type or print) First ALICE Middle -- Last CUFF		4. DATE OF DEATH Month JUNE Day 30 Year 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/14/1890
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) SCOTLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS B. MCGREGOR		14. MOTHER'S MAIDEN NAME MARGARET BROWNE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	
17. INFORMANT HOSPITAL RECORDS, OLNEY, MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CARDIAC FAILURE DUE TO CORONARY THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH 15 DAYS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JUNE 17, 1960 to JUNE 30, 1960 that (I) (we) last saw the deceased alive on JUNE 30, 1960 , and that death occurred at 12 M, from the causes and on the date stated above.			
22a. SIGNATURE C. S. Whitaker		22b. DATE SIGNED 7/1/60	
22c. PHYSICIAN'S NAME (Type) C. S. WHITAKER, M. D.		22d. ADDRESS CLARKSVILLE, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 2 1960	
23c. NAME OF CEMETERY OR CREMATORY Woodside		23d. LOCATION (City, town, or county) (State) Brinklow Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber		25a. REC'D BY REGISTRAR DATE JUL 5 '60	
ADDRESS Laytonsville, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

CERTIFICATE OF DEATH

7111

NOT THOROUGHLY

MAINTAINED

CLASSIFIED

12 DAYS

STEWART COUNTY GENERAL HOSPITAL

DECEASED

DATE

JUNE 30 1960

WHITE

SEX

CO

HOMEOWNERS

RECORDS

THOMAS A. HENDERSON

RECORDS

DATE

RECORDS, LOCAL, HAVEN

ACUTE CARDIAC FAILURE ONE IN TEN DAYS

12 DAYS

12 MONTHS

FILED

JUNE 30 1960

U.S. DEPARTMENT OF HEALTH

BRITAIN 1960 1960

BRITAIN

BRITAIN 1960 1960

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
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VR A15 (4)
15M 9/59

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M
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CP
RN
7112
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07036

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 40 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairfax 83X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS Rt. 5, Box 310			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Paul Middle Michael Last CURRAN				4. DATE OF DEATH Month June Day 3 Year 1960			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-4-02	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Naval Officer				10b. KIND OF BUSINESS OR INDUSTRY U.S.Navy		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Michael Joseph CURRAN				14. MOTHER'S MAIDEN NAME Mary Agnes FOLEY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) 1921-1955				16. SOCIAL SECURITY NO. (W) Mrs. Mary V. Curran, same as #28 above			
17. INFORMANT (W) Mrs. Mary V. Curran, same as #28 above				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infarction, myocardium 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 1 hour 2 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) did not attended the deceased from June 3 1960 to June 3 1960, that (I) xx last saw the deceased alive on June 3 1960, and that death occurred at 11:25 PM M, from the causes and on the date stated above.							
22a. SIGNATURE Joseph E. Stitcher				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6-4-60	
22c. PHYSICIAN'S NAME (Type) Joseph E. STITCHER, LT, MC, USN U.S.Naval Hospital, Bethesda, Md.				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 6/7/60		23c. NAME OF CEMETERY OR CREMATORY Arlington National	
23d. LOCATION (City, town, or county) (State) Arlington Virginia							
24. FUNERAL DIRECTOR'S SIGNATURE EVERLY FUNERAL HOME 214 W. MAIN ST. FAIRFAX VA.				25a. REC'D BY REGISTRAR 7 '60		25b. REGISTRAR'S SIGNATURE Walter S. ...	

CERTIFICATE OF DEATH

1115

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VR A15 (4)
15M 9/59

7078

7078

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07057

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>57 Bethesda, 14</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens SAN</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>HALE</u> Last <u>DARBY</u>		4. DATE OF DEATH Month <u>6</u> Day <u>24</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-19-04</u>
9. AGE (In years lost birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ARCHITECT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WM. R. DARBY</u>		14. MOTHER'S MAIDEN NAME <u>CLAIRE HALE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-14-5578</u>	
17. INFORMANT Address <u>Elinor R. Darby-wife-same as 2d</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarct</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4-5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/9/60</u> to <u>6/24/60</u> , that (I) (we) last saw the deceased alive on <u>5/21/60</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Manfred Steiner</u> M.D.		22b. DATE SIGNED <u>June 24 '60</u>	
22c. PHYSICIAN'S NAME (Type) <u>MANFRED STEINER</u>		22d. ADDRESS <u>2300 K ST. N.W. Wash, DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/27/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>June 28 '60</u>	
ADDRESS <u>Bethesda, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

57

Myocardial infarct
Coronary artery disease

7073

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg				c. LENGTH OF STAY IN 1b 2yrs 7 mo.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Asbury Methodist Home				d. STREET ADDRESS 516 Marietta St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Carrie Virginia Dawson				4. DATE OF DEATH Month Day Year June 3 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 19, 1867	
9. AGE (In years lost birthday) 93 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Near Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY None			
13. FATHER'S NAME Eli W. Dawson				14. MOTHER'S MAIDEN NAME Lucy Jacobs			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None			
17. INFORMANT Asbury Methodist Home, Gaithersburg, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Auniclar fibulation DUE TO (c) Pneumonia							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Nov. 13 , 19 57 to June 3 , 1960, that I last saw the deceased alive on June 1 , 19 60 , and that death occurred at 4.10 P.M. the causes and on the date stated above. ADDRESS (Street, city or town, state) 10128 Cedar Land Kensington, Md. DATE SIGNED June 3, 1960							
ACTUAL SIGNATURE Sarah E. Glover				M.D. 10128 Cedar Land Kensington, Md.			
PHYSICIAN'S NAME (Type) Sarah E. Glover, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-6-60		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE E. C. Gartner ADDRESS 316 E. Diamond Gaithersburg, Md.				24a. REC'D BY REGISTRAR DATE JUN 6 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Evans	

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CERTIFICATE OF DEATH

7072



Allegany

Barryland

Montgomery

Barryland

Age 7 mo.

Geithersburg

210 Harbottle St.

The Ashbury Methodist Home

68

3

June

Dawson

Virginia

Garrick

23

March 19, 1907

White

Female

U. S. A.

Near Cumberland, Md.

None

Honolulu

Lucy Jacobs

Miss W. Benson

Ashbury Methodist Home, Geithersburg, Md.

None

10

Spontaneous rupture

uterine fibroid

metastasis

60

June 3

27

Nov. 13

60

June 1

A. 10 P. M.

June 3, 1907

10128 Cedar Lane
Kensington, Md.

Arch E. Glover, M. D.

Cumberland, Md.

Rose Hall Cemetery

6-6-00

Partial

Miss E. Edmond

E. U. Gardner

Geithersburg, Md.

7113

CERTIFICATE OF DEATH

07039

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Green</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Muir Kirk</u> 16X - 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation, Inc.</u>		d. STREET ADDRESS <u>Muir Kirk Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Perrey Elmer</u> Middle <u>Dent</u> Last <u>Dent</u>		4. DATE OF DEATH Month <u>June</u> Day <u>28</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OF RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 25, 1880</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>15</u> Hours <u>52</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>tenant farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Perrey Elmer Dent</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Posey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Leonard G. Dent</u>		Address <u>Muir Kirk Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line (or (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 3322X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>General arteriosclerosis</u> DUE TO (c) <u>unilateral</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>o. m.</u> <u>p. m.</u> Month <u>19</u> Day <u>19</u> Year <u>1960</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 28, 1960</u> , to <u>June 28, 1960</u> , that I last saw the deceased alive on <u>June 27, 1960</u> , and that death occurred at <u>12:21 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L W Malin</u> M.D.		ADDRESS (Street, city or town, state) <u>Riversdale, Md</u>	
PHYSICIAN'S NAME (Type) <u>L W Malin, M.D.</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 30, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St John's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Beltsville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Hamilton</u>		ADDRESS <u>North 37th</u>	
24a. REC'D BY REGISTRAR <u>Jul 5 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kane</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7114

07040

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN 1b 8hrs. 49 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 1 Rudder Green, S. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Girl Middle DISQUE Last				4. DATE OF DEATH Month June Day 12 Year 19 60			
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-11-60	
9. AGE (In years lost birthday) yrs. 8		10. IF UNDER 1 YEAR Months 49		11. IF UNDER 24 HRS. Hours 49			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Howard Olin DISQUE				14. MOTHER'S MAIDEN NAME BeVerly Carole SEBRING			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address (F) Howard O. Disque, same as #2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Defect of diaphragm, congenital DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 11 19 60 to June 12 19 60 that (I) (we) last saw the deceased alive on June 12 19 60 , and that death occurred at 2:52 pm from the causes and on the date stated above.							
22a. SIGNATURE H. L. Walton				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6-13-60	
22c. PHYSICIAN'S NAME (Type) H. L. WALTON, LT, MS, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-14-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Mattingly Funeral Home, 131 11th St. S.E., WashDC				25a. REC'D BY REGISTRAR DATE JUN 14 '60		25b. REGISTRAR'S SIGNATURE Arthur E. Kneas	

Monogamy

3-11-60 (1961)

Time 12 min. Washington

U. S. Naval Hospital

1 Robert Green, S. N.

Baby Girl

Birth

Time

Female - Caucasian

6-11-60

None

Malaysia

Robert Green

Robert Green

NO

Name

(?) Howard G. Dwyer, born on 12 Nov 1911

Index of Names, continued

H. L. WALKER, JR., MC, USN

U. S. Naval Hospital, Bethesda, Md.

6-11-60

Washington National

Virginia

Postally Control is with S. S. L. WALKER

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7079

07041

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brookdale 56	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Sanitarium		d. STREET ADDRESS 4608 Overbrook Road 1	
3. NAME OF DECEASED (Type or print) First HULDA Middle L Last DOERR		4. DATE OF DEATH Month June Day 28 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/29/1877
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY School Teacher	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Luckel		14. MOTHER'S MAIDEN NAME Margaret Roder	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Col. Paul L. Doerr		Address Same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis, multiple DUE TO 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis, advanced DUE TO 5 yrs + (c) Arteriosclerosis, generalised 5 yrs + PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Aphasia, global, old, due to old cerebral thrombosis			INTERVAL BETWEEN ONSET AND DEATH 2 days 5 yrs + 5 yrs +
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1957 to June 28, 1960 , that (I) (we) last saw the deceased alive on June 23, 1960 , and that death occurred at 9:20 PM , from the causes and on the date stated above.			
22a. SIGNATURE Stewart Clapp M.D.		22b. DATE SIGNED 6/28/60	
22c. PHYSICIAN'S NAME (Type) Stewart Clapp		22d. ADDRESS 3921 Ingomar St N.W. Wash DC	
23a. BURIAL, CREMATION, or other disposition (Specify) BURIAL		23b. DATE THEREOF July 1, 1960	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City, town, or county) (State) Suitland Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Jas. Sauter's Sons & Wash. D.C.		25a. REC'D BY REGISTRAR JUN 29 '60	
25b. REGISTRAR'S SIGNATURE Charles S. Kneass			

CHIEF TAIN

1

7075

TERMINAL OF DEATH

NAME	DATE	PLACE	REMARKS
Henry James	1891	London	
John P. Jones	1892	London	
John P. Jones	1893	London	
John P. Jones	1894	London	
John P. Jones	1895	London	
John P. Jones	1896	London	
John P. Jones	1897	London	
John P. Jones	1898	London	
John P. Jones	1899	London	
John P. Jones	1900	London	
John P. Jones	1901	London	
John P. Jones	1902	London	
John P. Jones	1903	London	
John P. Jones	1904	London	
John P. Jones	1905	London	
John P. Jones	1906	London	
John P. Jones	1907	London	
John P. Jones	1908	London	
John P. Jones	1909	London	
John P. Jones	1910	London	
John P. Jones	1911	London	
John P. Jones	1912	London	
John P. Jones	1913	London	
John P. Jones	1914	London	
John P. Jones	1915	London	
John P. Jones	1916	London	
John P. Jones	1917	London	
John P. Jones	1918	London	
John P. Jones	1919	London	
John P. Jones	1920	London	
John P. Jones	1921	London	
John P. Jones	1922	London	
John P. Jones	1923	London	
John P. Jones	1924	London	
John P. Jones	1925	London	
John P. Jones	1926	London	
John P. Jones	1927	London	
John P. Jones	1928	London	
John P. Jones	1929	London	
John P. Jones	1930	London	
John P. Jones	1931	London	
John P. Jones	1932	London	
John P. Jones	1933	London	
John P. Jones	1934	London	
John P. Jones	1935	London	
John P. Jones	1936	London	
John P. Jones	1937	London	
John P. Jones	1938	London	
John P. Jones	1939	London	
John P. Jones	1940	London	
John P. Jones	1941	London	
John P. Jones	1942	London	
John P. Jones	1943	London	
John P. Jones	1944	London	
John P. Jones	1945	London	
John P. Jones	1946	London	
John P. Jones	1947	London	
John P. Jones	1948	London	
John P. Jones	1949	London	
John P. Jones	1950	London	
John P. Jones	1951	London	
John P. Jones	1952	London	
John P. Jones	1953	London	
John P. Jones	1954	London	
John P. Jones	1955	London	
John P. Jones	1956	London	
John P. Jones	1957	London	
John P. Jones	1958	London	
John P. Jones	1959	London	
John P. Jones	1960	London	
John P. Jones	1961	London	
John P. Jones	1962	London	
John P. Jones	1963	London	
John P. Jones	1964	London	
John P. Jones	1965	London	
John P. Jones	1966	London	
John P. Jones	1967	London	
John P. Jones	1968	London	
John P. Jones	1969	London	
John P. Jones	1970	London	
John P. Jones	1971	London	
John P. Jones	1972	London	
John P. Jones	1973	London	
John P. Jones	1974	London	
John P. Jones	1975	London	
John P. Jones	1976	London	
John P. Jones	1977	London	
John P. Jones	1978	London	
John P. Jones	1979	London	
John P. Jones	1980	London	
John P. Jones	1981	London	
John P. Jones	1982	London	
John P. Jones	1983	London	
John P. Jones	1984	London	
John P. Jones	1985	London	
John P. Jones	1986	London	
John P. Jones	1987	London	
John P. Jones	1988	London	
John P. Jones	1989	London	
John P. Jones	1990	London	
John P. Jones	1991	London	
John P. Jones	1992	London	
John P. Jones	1993	London	
John P. Jones	1994	London	
John P. Jones	1995	London	
John P. Jones	1996	London	
John P. Jones	1997	London	
John P. Jones	1998	London	
John P. Jones	1999	London	
John P. Jones	2000	London	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7115 CERTIFICATE OF DEATH

07042

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>New York</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>20 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New York</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>516 East 13th Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Antonino</u> Middle <u>(None)</u> Last <u>Dovi</u>				4. DATE OF DEATH Month <u>June</u> Day <u>11</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 10, 1929</u>	
9. AGE (In years last birthday) <u>31</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shoemaker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Shoe</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Italy</u>							
13. FATHER'S NAME <u>Salvatore Dovi</u>				14. MOTHER'S MAIDEN NAME <u>Santa Azzolina</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Aortic Insufficiency</u> DUE TO (c) <u>Rheumatic Heart Disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>Acute</u> <u>20 years</u> <u>21 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Aortic Valvulotomy on Extracorporeal Circulation</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>May 22, 1960</u> to <u>June 11, 1960</u> , that (I) (we) last saw the deceased alive on <u>June 11, 1960</u> , and that death occurred at <u>1:20 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Lazar Greenfield, M.D.</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>6-12-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>LAZAR GREENFIELD, M.D.</u>				22d. ADDRESS <u>The Clinical Center Bethesda 14 National Institutes of Health Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit</u>				23b. DATE THEREOF <u>6/13/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Unknown</u>	
23d. LOCATION (City, town, or county) <u>New York City</u>				(State) <u>New York</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert H. Pumpkin</u>				ADDRESS <u>Bethesda, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 20 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>							



Handwritten signature or text at the bottom right, possibly reading "J. B. ..."

Faint handwritten text at the bottom left, possibly "New York City"

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

07043

7027

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 11 YEARS	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION 11803 Judson Rd.		d. STREET ADDRESS 11803 JUDSON ROAD	
3. NAME OF DECEASED (Type or print) First Middle Last LAWRENCE DAVID DURRETTE, SR.		4. DATE OF DEATH Month Day Year JUNE 23, 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 4, 1920
9. AGE (In years last birthday) 39 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STAFF ASST.		10b. KIND OF BUSINESS OR INDUSTRY PHONE Co.	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH DIXON DURRETTE		14. MOTHER'S MAIDEN NAME FANNIE RHODES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES NAVY		16. SOCIAL SECURITY NO. 290-12-4039	
17. INFORMANT, Address (SAME ADDRESS)		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO 420 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Heart Disease DUE TO (c) ESSENTIAL HYPERTENSION	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) NONE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 1957 , to June 23, 1960 , that I last saw the deceased alive on June 23, 1960 , and that death occurred at 12:05 M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Belden R. Reap M.D.		ADDRESS (Street, city or town, state) 11502 Branigan Ave. Wheaton, Md.	
PHYSICIAN'S NAME (Type) BELDEN R. REAP		DATE SIGNED 6/23/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JUNE 25, 1960	
22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc.		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR JUN 27 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

CERTIFICATE OF DEATH

505

73

NAME OF DECEASED LAWRENCE, DANIEL		DATE OF BIRTH JAN 1 1902		PLACE OF BIRTH BALTIMORE, MARYLAND	
MARRIAGE MARRIED		DATE OF MARRIAGE JUN 1 1925		PLACE OF MARRIAGE BALTIMORE, MARYLAND	
SEX MALE		RACE WHITE		RELIGION METHODIST	
EDUCATION HIGH SCHOOL		OCCUPATION LABORER		MILITARY SERVICE NONE	
PREVIOUS ILLNESS NONE		CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
DATE OF DEATH JUN 1 1950		PLACE OF DEATH BALTIMORE, MARYLAND		CERTIFICATE NO. 505	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESS (None)		SIGNATURE OF PHYSICIAN (None)	
DATE OF SIGNATURE (None)		DATE OF SIGNATURE (None)		DATE OF SIGNATURE (None)	

TO DEPARTMENT OF HEALTH, MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form No. 13. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7116

07044

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brinklow d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		MARYLAND c. LENGTH OF STAY IN 1 yr.		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brinklow d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Clarence Clinton Dyson		First Clarence		Middle Clinton		Last Dyson		4. DATE OF DEATH Month June Day 29 Year 1960 19							
5. SEX male		6. COLOR OR RACE col		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/17/86		9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.				12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Charles Dyson				14. MOTHER'S MAIDEN NAME Annie Smith											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give year or dates of service)		17. INFORMANT Nora Dyson				Address Item 2							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 434.4 Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac hypertrophy DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH Found dead in chair at home					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE Frank J. Broschart				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 6/29/60							
EXAMINER'S NAME (Type) Frank J. Broschart				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/2/60		22c. NAME OF CEMETERY OR CREMATORY Pleasant View.,				22d. LOCATION (City, town, or country) (State) Quince Orchard, Md.							
23. FUNERAL DIRECTOR Robert L. Surden				ADDRESS Rockville, Md.				24a. REC'D BY REGISTRAR JUL 5 '60		24b. REGISTRAR'S SIGNATURE Robert L. Surden					

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June 22, 1911

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Angie Smith

John A. Lyon

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1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 7117 CERTIFICATE OF DEATH

07045
 07045

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>18 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>111 Southbrook Lane</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Robert</u> Last <u>Edmonds</u>		4. DATE OF DEATH Month <u>June</u> Day <u>21</u> Year <u>19 60</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 11, 1904</u>	9. AGE (In years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR Months <u>55</u> Days <u>55</u> Hours <u>55</u> Min. <u>55</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Superintendent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Concrete Products</u>		11. BIRTHPLACE (State or foreign country) <u>Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William F. Edmonds</u>				14. MOTHER'S MAIDEN NAME <u>Cora Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-10-4682</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary congestion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bronchogenic carcinoma</u> DUE TO (c) <u>11 months</u>							INTERVAL BETWEEN ONSET AND DEATH <u>11 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 3, 19 60</u> to <u>June 21, 19 60</u> that (I) (we) last saw the deceased alive on <u>June 21, 19 60</u> and that death occurred at <u>9:35 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Charles E. Mengel</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>6/21/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles E. Mengel, M.D.</u>				22d. ADDRESS <u>The Clinical Center, NIH Bethesda 14, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/24/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co. 2901 14th St., N.W.</u>				25a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7113
CERTIFICATE OF DEATH

07046

1. PLACE OF DEATH a. COUNTY Montgomery M b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 82 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY 75X-3 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carlisle d. STREET ADDRESS R.D. # 1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle Paul Last Eichhorn		4. DATE OF DEATH Month June Day 25 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 19, 1950
9. AGE (In years last birthday) 10 yrs.		IF UNDER 1 YEAR: Months 10 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Theodore F. Eichhorn		14. MOTHER'S MAIDEN NAME Mary E. Tanney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Disseminated aspergillosis DUE TO 204.3 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute lymphocytic leukemia DUE TO 3 years (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 3 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 1, 1960 to June 25, 1960 that (I) (we) last saw the deceased alive on June 25, 1960 and that death occurred at 7:40 PM from the causes and on the date stated above.			
22a. SIGNATURE Jerry S. Tripp M.D.		22b. DATE SIGNED 6/26/60	
22c. PHYSICIAN'S NAME (Type) JERRY S. TRIPP, M.D.		22d. ADDRESS The Clinical Center NIH, Bethesda 14, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/29/60	
23c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cemetery		23d. LOCATION (City, town, or county) (State) Cumberland Co. Penna.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR JUN 28 '60	
ADDRESS Bethesda, Maryland		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

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CERTIFICATE OF DEATH



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7119

CERTIFICATE OF DEATH

07047

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		d. STREET ADDRESS 3866 9th St., S.E. - Apt. 302	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joseph Middle (n) Last ERQUIZA		4. DATE OF DEATH Month June Day 21 Year 1960	
5. SEX Male	6. COLOR OR RACE Malayan	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-19-60
9. AGE (In years lost birthday) yrs. 2		IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jesus ERQUIZA		14. MOTHER'S MAIDEN NAME Ascension Vera BILLENA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 754.5 IMMEDIATE CAUSE (a) Congenital Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple Congenital Anomalies.		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from June 19 1960 to June 21 1960, that (I) (we) last saw the deceased alive on June 21 1960, and that death occurred at 9:55 AM, from the causes and on the date stated above.			
22a. SIGNATURE Fred W Grello		22b. DATE SIGNED 6-21-60	
22c. PHYSICIAN'S NAME (Type) Fred W. GRELLO, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-24-60	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Washington D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey		25a. REC'D BY REGISTRAR JUN 24 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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CENTRAL CHINA

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U. S. Embassy, Peking, China

1-24-50

Mr. A. G. ...

Mr. A. G. ...

1-24-50

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

FOR STATE
HEALTH DEPT.

(M)

(1)

MEDICAL CERTIFICATION

MONTGOMERY STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
07048											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Monty</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg R-3</u>						c. LENGTH OF STAY IN <u>12 yrs</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Longcroft Rd</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Oliver Virginia Estes</u>						4. DATE OF DEATH <u>June 15 1960</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 17-1919</u>		9. AGE (In years last birthday) <u>40</u> yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>						10b. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (State or foreign country) <u>va</u>						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>John W. Rines</u>						14. MOTHER'S MAIDEN NAME <u>Mary Abel</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>						16. SOCIAL SECURITY NO. <u>229-36-1172</u>					
17. INFORMANT <u>Everett V. Estes Sr.</u>						Address <u>Itan 2</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>Sudden death in bed</u> (a), stating the underlying cause last. (c) <u>due to</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						22b. DATE THEREOF <u>6/17/60</u>					
22c. NAME OF CEMETERY OR CREMATORY <u>Darnestown Church Cem</u>						22d. LOCATION (City, town, or country) (State) <u>Darnestown, Maryland</u>					
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>						ADDRESS <u>Bethesda, Maryland</u>					
24a. REC'D BY REGISTRAR <u>JUN 16 '60</u>						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Haus</u>					

7

Figure 10.10

55-36-252

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1915

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7122

CERTIFICATE OF DEATH

07050

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		MARYLAND c. LENGTH OF STAY IN 1b 21 hrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Midway Island d. STREET ADDRESS Davis Apartments e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Robyn Ann FARRINGTON			4. DATE OF DEATH Month Day Year June 18 1960		
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-17-60	9. AGE (In years lost birthday) yrs. 1	IF UNDER 1 YEAR Months Days Hours Min. 1 2 0 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Daniel O. FARRINGTON			14. MOTHER'S MAIDEN NAME Judy Ann LIDDY		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) - - - - -		17. INFORMANT Address Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGENITAL DIAPHRAGMATIC HERNIA (POST OPERATIVE) 560.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 36 HRS					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. June 18 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) June 18 1960	
21. I certify that (I) physician attended the deceased from June 18 1960 10:10PM to June 18 1960 , that (I) xxx lost saw the deceased alive on June 18 1960 , and that death occurred at 10:10PM M, from the causes and on the date stated above.					
22a. SIGNATURE C. W. Bramlett 22c. PHYSICIAN'S NAME (Type) C. W. BRAMLETT, LT, MC, USN		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.		22b. DATE SIGNED 6-19-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-21-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Humphrey R. A. Humphrey Funeral Home, Bethesda, Md.		ADDRESS Arlington Va.		23d. LOCATION (City, town, or county) (State)	
25a. REC'D BY REGISTRAR DATE JUN 21 '60		25b. REGISTRAR'S SIGNATURE Arthur L. House			

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DAVID C. FAULKNER

TABLE 1. *Continued*

Healthcare

7123

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban				d. STREET ADDRESS Hilltop Golf Lane			
3. NAME OF DECEASED (Type or print) First Middle Last James D Ferguson Jr.				4. DATE OF DEATH Month Day Year June 17 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/22/15		9. AGE (In years last birthday) 45 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Consulting		11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Du Bose Ferguson Sr.				14. MOTHER'S MAIDEN NAME Mathilde McIntire			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Wife Kate S. Ferguson		Address Hilltop Golf Lane Rockville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC FAILURE 580X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Hepatic Necrosis, etiology indeterminate DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 5 days 3 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 6 , 19 55 , to June 17 , 19 60 , that I last saw the deceased alive on June 16 , 19 60 , and that death occurred at 5:19A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert G. Angelle		ADDRESS (Street, city or town, state) 5009 DelRay Ave, Bethesda, Md DATE SIGNED 4/17/60					
PHYSICIAN'S NAME (Type) Robert G. Angelle		5009 DelRay Ave. Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/18/60		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE JUN 20 '60	
				24b. REGISTRAR'S SIGNATURE Arthur L. House			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1153

CERTIFICATE OF DEATH

State of New York

County of ...

City of ...

Decedent's name ...

Age ...

Sex ...

Marital status ...

Occupation ...

Place of birth ...

Date of death ...

Time of death ...

Place of death ...

Cause of death ...

Signature of physician ...

Signature of coroner ...

Signature of registrar ...

Signature of witness ...

Signature of ...

Signature of ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7124

CERTIFICATE OF DEATH

07052

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Tennessee</u> b. COUNTY <u>Washington</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Johnson City</u> 79X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>		d. STREET ADDRESS <u>Route # 1, Greenwood Drive</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jack Leon Fillers</u>		4. DATE OF DEATH Month Day Year <u>June 8 19 60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 5, 1934</u>
9. AGE (In years last birthday) <u>26</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attendant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Service Station</u>	
11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Bruce Fillers</u>		14. MOTHER'S MAIDEN NAME <u>Bonnie McKinney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>411-48-3803</u>	
17. INFORMANT <u>The Medical Record</u>		Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hodgkins Disease</u> DUE TO (c) <u>Pneumonitis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5m</u> <u>1 yr.</u> <u>1 wkc</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 17, 1960</u> to <u>June 8, 1960</u> , that (I) (we) last saw the deceased alive on <u>June 8, 1960</u> , and that death occurred at <u>8:40 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Harold J. Fallon</u> M.D.		22b. DATE SIGNED <u>6/9/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Harold J. Fallon, M. D.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>6-11-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MONTE-VISTA</u>		23d. LOCATION (City, town, or county) (State) <u>Johnson City, Tenn.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>MAY 13 '60</u>	
ADDRESS <u>Bethesda</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

00000

CERTIFICATE OF DEATH



[Faint, illegible text and markings on a form, likely a death certificate. The text is mirrored and difficult to decipher.]

CERTIFICATE OF DEATH

Reg. Dist. No. 07053

7125

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Elmer</u> Last <u>Fisher</u>				4. DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 21, 1914</u>	
9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months <u>45</u> Days <u>45</u> Hours <u>45</u> Min. <u>45</u>		IF UNDER 24 HRS. Months <u>45</u> Days <u>45</u> Hours <u>45</u> Min. <u>45</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Police man</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Washington Metropolitan Police</u>			
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>James M. Fisher</u>				14. MOTHER'S MAIDEN NAME <u>Virginia. Estes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>YES</u>			
17. INFORMANT <u>Doris L. Fisher</u>				Address <u>(same as above)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>581.0</u> DUE TO <u>Coarctation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cirrhosis of Liver</u> DUE TO <u>Pancreatitis chronic</u> (c) <u>subur</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 month</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>2/1</u> , 19 <u>59</u> , to <u>6/29</u> , 19 <u>60</u> that I last saw the deceased alive on <u>6/29</u> , 19 <u>60</u> , and that death occurred at <u>6:15</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Rockville, Md</u> DATE SIGNED <u>6/29/60</u>							
ACTUAL SIGNATURE <u>Stephen N. Jones</u>				PHYSICIAN'S NAME (Type) <u>STEPHEN N. JONES</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>7/2/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEMETERY</u>	
22d. LOCATION (City, town, or county) <u>MONTGOMERY COUNTY, MARYLAND</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Jaska</u>				ADDRESS <u>SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>JUL 6 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kiana</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13453

CERTIFICATE OF DEATH

1918

DECEASED

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7126

CERTIFICATE OF DEATH

Reg. Dist. No.

07054

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maine</u> b. COUNTY <u>Kennebec</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY in 1b <u>74 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hallowell</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>18 Page Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Hope</u> Middle <u>Gladys</u> Last <u>Fisher</u>				4. DATE OF DEATH Month <u>June</u> Day <u>1</u> Year <u>19 60</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 10, 1902</u>	
9. AGE (In years lost birthday) <u>57</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maine</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Holman Currier</u>			
14. MOTHER'S MAIDEN NAME <u>Clara White</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>Unascertainable</u>				17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema and bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adrenal cortical carcinoma</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>1 year</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>March 19</u> , 19 <u>60</u> , to <u>June 1</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>June 1</u> , 19 <u>60</u> , and that death occurred at <u>11:20A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Saul Genuth</u> M.D.				ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>6/1/60</u>			
PHYSICIAN'S NAME (Type) <u>Saul Genuth, M. D.</u>				National Institutes of Health <u>Bethesda 14, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>		22b. DATE THEREOF <u>6/5/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Augusta, Maine</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 3 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Haines</u>	

7127

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Margaret Middle R Last Flaherty				4. DATE OF DEATH Month June Day 6 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/29/1912	
9. AGE (In years lost birthday) 47 yrs.		IF UNDER 1 YEAR Months 10 Days 7 Hours Min. 		IF UNDER 24 HRS. Months Days Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) Min., Minnesota	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME John				14. MOTHER'S MAIDEN NAME Annie Kirwin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT Thomas F. Flaherty-husband-same 2d				Address 			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma-Generalized DUE TO Cachexia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 Mos.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	
20f. (City or town) 				20g. (County) 		20h. (State) 	
21. I certify that I attended the deceased from JUNE 4 , 19 58 , to JUNE 6 , 19 60 that I last saw the deceased alive on MAY 27 , 19 60 , and that death occurred at 3 A. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Phillip A. Caulfield				DATE SIGNED 6/6/60			
PHYSICIAN'S NAME (Type) Phillip A. Caulfield				ADDRESS (Street, city or town, state) 8 W. Lenox St. Ch. Ch. Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/9/60		22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		22d. LOCATION (City, town, or county) (State) Silver Spring, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR JUN 8 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

47

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07056

Reg. Dist. No.

7128

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>6 Hrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Dallas Francis Flynn</u>				4. DATE OF DEATH Month Day Year <u>June 5 19 60</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 6, 1877</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Flynn</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Hefflin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>101 Indian Sp Rd. Silver Spring, Md</u>			
17. INFORMANT <u>Mrs. Kathryn Lindgreen (Daughter)</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>231X</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Brochart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Brochart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 8, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fairfax</u>		22d. LOCATION (City, town, or county) (State) <u>Fairfax, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Everly Funeral Home</u> <u>By [Signature] Manager</u> <u>Fairfax, Virginia</u>				24a. REC'D BY REGISTRAR <u>JUN 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hays</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

45

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18														
7051					CERTIFICATE OF DEATH									
1. PLACE OF DEATH o. COUNTY					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE									
Montgomery MARYLAND					Maryland									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)									
Takoma Park					37 Silver Spring									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					d. STREET ADDRESS									
Washington Sanitarium & Hospital					2806 Ivydale									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH									
First Middle Last					Month Day Year									
Fowle					June 18 1960									
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years lost birthday) yrs.						
female		white				6-16-60		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. 2 9 12						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country)				
										Maryland				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					12. CITIZEN OF WHAT COUNTRY?				
Morgan Rene Fowle					Mary Elizabeth Moyers					United States				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT Address				
no										mother				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interventricular septal defect 754.2 DUCTOX Patent foramen ovale & Patent Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUCTO Ductus Arteriosus (c) (Congenital Heart Disease)										INTERVAL BETWEEN ONSET AND DEATH 57 hr, 12 min				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour o. m. p. m. 19					20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
										20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 6-16, 1960, to 6-18, 1960, that I last saw the deceased alive on 6-17, 1960, and that death occurred at 1:35 P.M., from the causes and on the date stated above.														
ACTUAL SIGNATURE Robert O. Warthen, M.D.										ADDRESS (Street, city or town, state) DATE SIGNED 3716 HOWARD AVE. 6-18-60				
PHYSICIAN'S NAME (Type) Robert Warthen, M.D.										KENSINGTON, MD.				
22a. BURIAL, CREMATION, REMOVAL (Specify)					22b. DATE THEREOF					22c. NAME OF CEMETERY OR CREMATORY				
cremation					6-22-60					Wash. San & Hosp				
23. FUNERAL DIRECTOR'S SIGNATURE					ADDRESS					24a. REC'D BY REGISTRAR				
Robert Hare, M.D., Wash. San & Hosp.										DATE JUN 28 '60				
										24b. REGISTRAR'S SIGNATURE				
										Arthur S. Hanes				

VS A15 (4)
15M 10/57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7028 CERTIFICATE OF DEATH

07058

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 16 SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9707 DILSTON ROAD		d. STREET ADDRESS 1 9707 DILSTON ROAD	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ALFONSO Middle S. Last FUSCO		4. DATE OF DEATH Month JUNE Day 1 Year 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/30/24
9. AGE (In years lost birthday) 36 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EXAMINER		12. KIND OF BUSINESS OR INDUSTRY I.C.C. Federal Gov't. Washington, D.C.	
13. FATHER'S NAME Salvatore Fusco		14. MOTHER'S MAIDEN NAME Camilla XXXXX De Nenna	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. WW #2 577-28-9036	
17. INFORMANT Mrs. Rita A. Fusco, 9707 Dilston Rd.		Address Silver Spring	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X DUE TO Broncho pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of the male breast tissue DUE TO (c) 8 months PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 3 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 1960 to June 1, 1960 that (I) (we) last saw the deceased alive on June 1, 1960 and that death occurred at 4:00 PM, from the causes and on the date stated above.			
22a. SIGNATURE Ralph F. Patten		22b. DATE 6/1/60	
22c. PHYSICIAN'S NAME (Type) RALPH F. PATTEN MD		22d. ADDRESS 8641-Colesville Road Silver Spring, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/6/60	
23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY		23d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Janka		25a. REC'D BY REGISTRAR DATE JUN 9 '60	
ADDRESS SILVER SPRING, MD.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

7028

CERTIFICATE OF DEATH

7028

16

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7070
CERTIFICATE OF DEATH

07059

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b 15 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4727 Essex Street Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle M Last Gerig		4. DATE OF DEATH Month June Day 7 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/13/98
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months 4 Days 28	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Ohio	11. BIRTHPLACE (State or foreign country) US
13. FATHER'S NAME ? Blosser		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT O. Benjamin Gerig-Husband-same 2d		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) Acute Cardiac Distention DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 10-15 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Hypertension		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that (I) (this hospital) attended the deceased from June 2 19 60 to June 7 19 60 , that (I) (we) last saw the deceased alive on June 7 19 60 , and that death occurred at 7:45 PM , from the causes and on the date stated above.			
22a. SIGNATURE W. B. Wardrop MD		22b. DATE SIGNED 6/7/60	
22c. PHYSICIAN'S NAME (Type) W. B. WARDROP MD		22d. ADDRESS 800 PERSHING DRIVE SILVER SPRING MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/10/60	
23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City, town, or county) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR June 10 '60	
ADDRESS Bethesda, Maryland		25b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

55

02050

CERTIFICATE OF DEATH

2020



Name: Robert A. Demaree
 Date of Birth: 1910
 Sex: Male
 Race: White
 Marital Status: Married
 Occupation: Farmer
 Address: 1234 Main Street, Springfield, Ohio
 Date of Death: 10/15/2020
 Cause of Death: Heart Disease
 Place of Death: Home
 Signature: [Signature]
 Registrar: [Signature]
 Date: 10/20/2020

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7052

CERTIFICATE OF DEATH

07060

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>8701 Barron Street</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Karen</u> Middle <u>Ann</u> Last <u>GOFORTH</u>				4. DATE OF DEATH Month <u>June</u> Day <u>24</u> Year <u>1960</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 21, 1960</u>	
9. AGE (In years lost birthday) yrs. <u>—</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>baby</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>not given</u>				14. MOTHER'S MAIDEN NAME <u>Patricia Ann Goforth</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>mother</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/24/60</u> , 19 <u>60</u> , to <u>6/24</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>6/24/60</u> , 19 <u>60</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H. H. Diamond</u>				ADDRESS (Street, city or town, state) <u>8248 - Georgia Ave</u> DATE SIGNED <u>6/24/60</u>			
PHYSICIAN'S NAME (Type) <u>H. H. DIAMOND</u>				<u>Angel Silver Spring Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>6-28-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wash. Sanitarium & Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Takoma Park Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Hare, M.D., Wash. San. & Hosp. Takoma Park, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 6 1960</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

22 75202 XV1

CERTIFICATE OF DEATH

1952

1952

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		MAY 19 1928		MEMPHIS, TENN.	
RACE		SEX		MARRIED	
WHITE		MALE		MARRIED	
EDUCATION		OCCUPATION		CAUSE OF DEATH	
HIGH SCHOOL		LABORER		HEART DISEASE	
RELIGION		MILITARY SERVICE		DATE OF DEATH	
METHODIST		NONE		MAY 2 1968	
PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH	
MEMPHIS, TENN.		MAY 2 1968		10:00 AM	
CERTIFICATE NO.		REGISTERED BY		SIGNATURE OF REGISTRAR	
1000000		J. E. RAY		[Signature]	
LOCAL HEALTH OFFICER		STATE HEALTH OFFICER		FEDERAL HEALTH OFFICER	
[Signature]		[Signature]		[Signature]	

DECEASED
JAMES EARL RAY
MAY 2 1968

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND STATE DEPARTMENT OF HEALTH - BIRTH - DEATH - RECORDS.

7129

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>3 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Theodosia Hardy Goodwin</u>				4. DATE OF DEATH Month Day Year <u>JUNE 25, 1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/18/95</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>manager</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>private</u>			
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Clayton Goodwin</u>				14. MOTHER'S MAIDEN NAME <u>Hardy (THEODOSIA)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>Theodosia Johnson</u>				Address <u>Bethesda, Md. 10010 Frederick Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Coronary atherosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Indefinite</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb. 2, 1957</u> , to <u>6/25, 1960</u> , that I last saw the deceased alive on <u>6/25, 1960</u> , and that death occurred at <u>6:50</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Rochville, Md.</u> DATE SIGNED <u>6/26/60</u>							
ACTUAL SIGNATURE <u>Stephen W. Jones</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Stephen W. Jones</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>6/29/60</u>		<u>LOUDON PARK</u>		<u>BALTIMORE, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers</u>				ADDRESS <u>1400 Chapel St. N.W.</u>			
24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>				24b. REGISTRAR'S SIGNATURE			
DATE <u>JUN 28 '60</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

41

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07062

Reg. Dist. No.

7130

Item 9 FilmG265 6-21-60 et

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 1 1/2 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban				d. STREET ADDRESS 1619 61 st. Ave.			
3. NAME OF DECEASED (Type or print) First Claymond Middle August Last Granam				4. DATE OF DEATH Month June Day 12 Year 19 60			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 20/1924		9. AGE (In years last birthday) 35 3/4 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY Sanitary Commission		11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Granam				14. MOTHER'S MAIDEN NAME Edna Thomas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes.		16. SOCIAL SECURITY NO. 2018 11 66		17. INFORMANT Address wife (Clarence house) same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Herniation of Brain Stem 822 <input checked="" type="checkbox"/> DUE TO Intracerebral Edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Basal Skull Fracture (b) Basal Skull Fracture (c) Basal Skull Fracture INTERVAL BETWEEN ONSET AND DEATH Sudden 2 hours 2 hours							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Was driven of auto which went out of control & upset							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 7:15 a.m. 6-12 Month, Day, Year 1960	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M. S. R-240		20f. (City or town) Rockville		(County) montg	(State) md
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschant				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) FRANK J. Broschant				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-16-1960		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat		22d. LOCATION (City, town, or county) (State) Wash D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE George & Nelson Aguiar				24a. REC'D BY REGISTRAR DATE JUN 15 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02063

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9301 Weaver Street</u>		d. STREET ADDRESS <u>1207 University Blvd. N.W. D.C.</u>	
3. NAME OF DECEASED (Type or print) <u>KATHRYN ENFIELD GRIGG</u>		4. DATE OF DEATH <u>June 28 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-10-69</u>
9. AGE (In years last birthday) <u>90</u> yrs.		10. IF UNDER 1 YEAR <u>6</u> Months <u>18</u> Days	11. IF UNDER 24 HRS. <u>18</u> Hours <u>18</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Johnstown Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lori Enfield</u>		14. MOTHER'S MAIDEN NAME <u>Louise Fredricks</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Dr. Oliver Thompson</u>		Address <u>1207 University Blvd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> 420.0 DUE TO <u>Acute Pulmonary Cong.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>Arteriosclerosis Heart D.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 wk.</u> <u>3 yrs</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 5</u> , 19 <u>58</u> , to <u>June 28</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>June 28</u> , 19 <u>60</u> , and that death occurred at <u>10:05</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Oliver E. Thompson</u> M.D.		ADDRESS (Street, city or town, state) <u>901 Pershing Dr. S.S. Md.</u>	
PHYSICIAN'S NAME (Type) <u>OLIVER E. THOMPSON</u>		DATE SIGNED <u>—</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>June 30, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Georges County, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>		ADDRESS <u>254 Carroll St. N.W. D.C.</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	
DATE <u>JUL 1 '60</u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

CERTIFICATE OF DEATH

1911

NOT IN COMPLIANCE WITH

REVIEWED BY BOARD

<p>1. Name of deceased: <i>John Doe</i></p>	
<p>2. Sex: <i>Male</i></p>	
<p>3. Age: <i>45</i></p>	
<p>4. Date of death: <i>Jan 15 1911</i></p>	
<p>5. Place of death: <i>Home</i></p>	
<p>6. Cause of death: <i>Heart Disease</i></p>	
<p>7. Signature of physician: <i>Dr. J. Smith</i></p>	
<p>8. Signature of registrar: <i>John Doe</i></p>	
<p>9. Signature of witness: <i>John Doe</i></p>	
<p>10. Signature of witness: <i>John Doe</i></p>	
<p>11. Signature of witness: <i>John Doe</i></p>	
<p>12. Signature of witness: <i>John Doe</i></p>	
<p>13. Signature of witness: <i>John Doe</i></p>	
<p>14. Signature of witness: <i>John Doe</i></p>	
<p>15. Signature of witness: <i>John Doe</i></p>	
<p>16. Signature of witness: <i>John Doe</i></p>	
<p>17. Signature of witness: <i>John Doe</i></p>	
<p>18. Signature of witness: <i>John Doe</i></p>	
<p>19. Signature of witness: <i>John Doe</i></p>	
<p>20. Signature of witness: <i>John Doe</i></p>	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7132

CERTIFICATE OF DEATH

07065

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 1 hr.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 307 Wellington Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Gerald Middle Leslie Last HANN				4. DATE OF DEATH Month June Day 15 Year 19 60			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-21-60	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months 4 Days 25		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Edgar L. HANN				14. MOTHER'S MAIDEN NAME Pattie PACE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure and aspheric spell cor biloculare 754.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 10 min. (c) 4 mo.				INTERVAL BETWEEN ONSET AND DEATH 2 weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Mongolism				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (X) (this hospital) attended the deceased from June 7 19 60 to June 15 19 60 that (X) (we) last saw the deceased alive on June 15 19 60 , and that death occurred at 3:12 PM , from the causes and on the date stated above.							
22a. SIGNATURE G. B. Avery				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 6-16-60	
22c. PHYSICIAN'S NAME (Type) G. B. AVERY, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/20/60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Wheatly Funeral Home, Alexandria, Va.				25a. REC'D BY REGISTRAR DATE JUN 17 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

2051421XV2

02065

CENTRAL OF DEATH

2133

Virginia

Massachusetts

Massachusetts (Royal)

301 William on Road

U. S. Naval Hospital

June

Mass

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June

Mass

Mass

Massachusetts

Mass

U.S.A.

Massachusetts

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Massachusetts

Massachusetts

Massachusetts

Mass

Mass

June

June

June

June

June

June

U. S. Naval Hospital, Massachusetts, MA

U. S. Naval Hospital, Massachusetts, MA

Virginia

Massachusetts

Mass

Massachusetts, MA

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7029

07066

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) e. STATE <u>md</u> b. COUNTY <u>Montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Silver Spring</u>		
c. LENGTH OF STAY IN lb <u>10 yrs</u>			d. STREET ADDRESS <u>18405 Piney Branch Rd</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>8405 Piney Branch Rd</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>John Bartholomew Hanson</u>			4. DATE OF DEATH <u>June 14 1960</u>		
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u>			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH <u>Aug 5 1904</u>			9. AGE (In years last birthday) <u>55</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dep. Com</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>U.S.C.</u>		
11. BIRTHPLACE (State or foreign country) <u>Iowa</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>		
13. FATHER'S NAME <u>Geo Hanson</u>			14. MOTHER'S MAIDEN NAME <u>Cora Reunick</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <u>Leona Hanson (wife)</u>			Address <u>Stem 2</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Throat hemorrhage</u> DUE TO (b) <u>Shot gun wound in left chest (heart)</u> DUE TO (c) <u>9776X</u>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self-inflicted shot gun wound</u>		
20c. TIME OF INJURY Month, Day, Year <u>3:30 p.m. 6-14 1960</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>			20f. (City or town) (County) (State) <u>Silver Spring Montg md</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschaw</u>			M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>FRANK J. BROSCAW</u>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
Address (Street, city, town, or county)			DATE SIGNED <u>6-14-60</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 20, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillview Cemetery</u>	
22d. LOCATION (City, town, or country) (State) <u>Hinsdale, Montana</u>		23. FUNERAL DIRECTOR <u>J. Arthur Walters, 254 Canal Street</u>			
24a. REC'D BY REGISTRAR <u>JUN 17 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

(M)

X

MEDICAL CERTIFICATION

17.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7133 CERTIFICATE OF DEATH

07067

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Pennsylvania</u> b. COUNTY <u>✓</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>97 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Emmaus</u> <u>75X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>			d. STREET ADDRESS <u>349 Spruce Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Foster</u> Last <u>Harries</u>			4. DATE OF DEATH Month <u>June</u> Day <u>17</u> Year <u>1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 31, 1920</u>		9. AGE (In years lost birthday) <u>39</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Textile Manufacturer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Textile</u>		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>	
13. FATHER'S NAME <u>Herbert D. Harries</u>			14. MOTHER'S MAIDEN NAME <u>Mamie Muhs</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>154-14-7655</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastrointestinal hemorrhage</u> <u>204.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute myelocytic leukemia</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>10 months</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>marrow</u>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 12</u> 19 <u>60</u> , to <u>June 17</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>June 17</u> 19 <u>60</u> , and that death occurred at <u>4:25 PM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>Paul J. Schwab</u>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>6/19/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>PAUL J. SCHWAB, M.D.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>6-21-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Grandview Cemetery</u>	
23d. LOCATION (City, town, or county)		(State)		23e. REC'D BY REGISTRAR DATE <u>JUN 21 '60</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>		ADDRESS <u>Bethesda, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

1970

CERTIFICATE OF DEATH

71



ROBERT A. STEPHENSON
BETHLEHEM, PA.
GRANDFATHER



RECEIVED

RECEIVED (MAY)

U. S. Naval Hospital

Michael

Arthur

MARIA

1900

Male

1-3-22

Female

Pennsylvania

Arthur W. HARRIS

John H. HARRIS

(P) Arthur W. HARRIS, born in 18 18 18



June 2 1900

June 12 1900

9-13-00

U. S. NAVY, U. S. MARINE CORPS

U. S. Naval Hospital, Bethesda, Md.

Butler

St. Joseph's Hospital

New York

William H. HARRIS, born in 18 18 18

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 1, 2, and 3 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7053

Item 14, Film G-272 10/3/60 cac.

07069

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASH. SANITARIUM</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>214 Silver Spring</u> d. STREET ADDRESS <u>132 Eastmook Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>Blythe</u> Last <u>Hayden</u>		4. DATE OF DEATH Month <u>6</u> Day <u>2</u> Year <u>1960</u>		5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-13-60</u> 9. AGE (In years last birthday) <u>30</u> yrs. IF UNDER 1 YEAR Months <u>30</u> Days <u>30</u> IF UNDER 24 HRS. Hours <u>30</u> Min. <u>30</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>WASH. D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter J. Hayden</u>		14. MOTHER'S MAIDEN NAME <u>MARY ANN QUINN</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>104</u>	
17. INFORMANT <u>Mr Woodrow Lucas</u>		Address <u>Same as above</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO <u>475X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>upper Respiratory Infection</u> DUE TO (c) <u>Asphyxia</u> INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Brosch</u>		M.D. <u>FRANK J. Brosch</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>6-2-60</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>		Address (Street, city, town, or county) <u>4812 Ga Ave NW</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22b. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22c. DATE THEREOF <u>6-4-60</u>		22d. NAME OF CEMETERY OR CREMATORY <u>St Marys Cem</u>		22e. LOCATION (city, town, or country) (State) <u>Washington DC</u>	
23. FUNERAL DIRECTOR <u>Deaf Funeral Home</u>		ADDRESS <u>4812 Ga Ave NW</u>		24a. REC'D BY REGISTRAR <u>JUN 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

STATE OF NEW YORK
COUNTY OF [illegible]

1
2



IN SENATE
JANUARY 1, 1903
REPORT OF THE
COMMISSIONER OF THE
LAND OFFICE
ON THE
LANDS BELONGING TO THE
STATE OF NEW YORK

1903

[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a detailed report or list of land parcels, possibly including names of owners, locations, and acreage. Some words like 'land', 'acre', and 'state' are faintly visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7080
07070
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. LENGTH OF STAY IN 1b unknown	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Sanitarium		d. STREET ADDRESS 1954 Columbia Road N. W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lilian Middle D. Last Heath		4. DATE OF DEATH Month June Day 11 Year 19 60	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/20/1884
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Felix M. Draney		14. MOTHER'S MAIDEN NAME Salome Harrison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. no	
17. INFORMANT William D. Heath-1111 Army Navy Dr.		Address Arlington, Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive heart failure DUE TO (c) Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 10 days 1 month 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 28 1949 to June 11 1960 that (I) (we) last saw the deceased alive on JUNE 10 19 60 and that death occurred at 11 PM , from the causes and on the date stated above.			
22a. SIGNATURE Horace H. Custis Jr. M.D.		22b. DATE SIGNED June 11/1960	
22c. PHYSICIAN'S NAME (Type) HORACE H. CUSTIS JR		22d. ADDRESS 1852 Columbia Rd NW	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/14/60	
23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE Thos. A. Anne Co. Wash D. C.		25a. REC'D BY REGISTRAR DATE JUN 14 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

5

03030

7086

TELETYPE UNIT

Montgomery

Washington

Washington

Washington

Washington Bureau Building

1775 Columbia Road N.W.

Allen

Allen

Allen

Samuel

White

Washington

36

Howard

Washington, D.C.

Allen A. Brown

Edison Harrison

20

William D. Hobbitt Army Navy Bldg.

RECEIVED
JAN 10 1945

Washington, D.C.

James O. Brown

RECEIVED
JAN 10 1945

Page 4 after death. The law requires that the death certificate be executed within 24 hours after death. The attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7135 CERTIFICATE OF DEATH

07071

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 5 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Congressional Manor		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 54 Chevy Chase	
		d. STREET ADDRESS 3912 Leland Street	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lucy Middle Knight Last Heyl		4. DATE OF DEATH Month June Day 24 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/23/1869
9. AGE (In years lost birthday) 91 yrs.		IF UNDER 1 YEAR Months 2 Days 1 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Nathan Delaney Daugherty		14. MOTHER'S MAIDEN NAME Mary Elizabeth Antis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Paul R. Heyl-Husband-same 2d			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mitral Insufficiency with cardiac hypertrophy 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pyelonephritis DUE TO (c) Cerebro-vascular accidents		INTERVAL BETWEEN ONSET AND DEATH over 50 yrs 2 yrs. 4 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 18, 1956 to June 24, 1960 that (I) (we) last saw the deceased alive on June 24, 1960 and that death occurred at 6:40 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Katharine A. Chapman M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Katharine A. Chapman		22d. ADDRESS Bethesda, Maryland	
22b. DATE SIGNED June 24, 1960			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 6/24/60		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City, town, or county) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR JUN 27 '60	
ADDRESS Bethesda, Maryland		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

54

7054

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> 1660.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hosp</u>				d. STREET ADDRESS <u>5609 29th Street Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>HERMAN</u> Middle <u>Elroy</u> Last <u>Hiatt</u>				4. DATE OF DEATH Month <u>June</u> Day <u>8</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-13-16</u>	
9. AGE (in years lost birthday) yrs. <u>84</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired. Soldier</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Army Map Service</u>			
11. BIRTHPLACE (State or foreign country) <u>Nebraska</u>				12. CITIZEN OF WHAT COUNTRY? <u>American</u>			
13. FATHER'S NAME <u>William Henry Hiatt</u>				14. MOTHER'S MAIDEN NAME <u>Cynthia Presnoble</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>				16. SOCIAL SECURITY NO. <u>Span-Amer</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY INSUFFICIENCY</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u> "			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>BRONCHOPNEUMONIA, EARLY, BILATERAL.</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Feb</u> , 19 <u>60</u> , to <u>June 8</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>April</u> , 19 <u>60</u> , and that death occurred at <u>5:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Leon L. Gahlin M.D.</u>				DATE SIGNED <u>9/8/60</u>			
PHYSICIAN'S NAME (Type) <u>LEON L. GAHLIN M.D.</u>				<u>7206 Colesville Rd., W. Hyattsville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>June 13, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bladensburg, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co.</u>				ADDRESS <u>5801-Cleveland</u>		24a. REC'D BY REGISTRAR <u>June 13 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Turner</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

68

7081

Item 1 Film G264 6-13-60 et

CERTIFICATE OF DEATH

Reg. Dist. No.

07073

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Kensington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Private home</u>				d. STREET ADDRESS <u>13915 Spruell Court.</u>			
3. NAME OF DECEASED (Type or print) <u>RETTA</u> First <u>C</u> Middle <u>Hickey</u> Last				4. DATE OF DEATH <u>June 2</u> 1960 Month Day Year			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 19, 1874</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>ROBERT SHARP</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH SHARP</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u> INFORMANT <u>GENEVIEVE WALLACE (DAUGHTER)</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u>							<u>1 wk</u>
332X DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u>							<u>sev. year</u>
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb.</u> 1960, to <u>6/2/</u> 1960, that I last saw the deceased alive on <u>5/20/</u> 1960, and that death occurred at <u>5:00</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Donald Nelson</u>				ADDRESS (Street, city or town, state) <u>10620 Georgia Ave, Silver Spring, Md.</u>			
DATE SIGNED							
PHYSICIAN'S NAME (Type) <u>Donald Nelson</u>				<u>10620 Georgia Ave, Silver Spring, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>6-6-60</u>		22b. DATE THEREOF <u>Lynnhurst.</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Shroville Tenn</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Lee Jones</u> ADDRESS <u>300-4518 E. North St.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 4 may be retained by the hospital or attending physician.

1901

CERTIFICATE OF DEATH

1901

X



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7136 CERTIFICATE OF DEATH

07074

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Texas b. COUNTY ✓					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 117 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dallas			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 6023 Lupton Drive					
3. NAME OF DECEASED (Type or print) First Marjorie Middle Louise Last Hill				4. DATE OF DEATH Month June Day 21 Year 19 60					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 4, 1923		9. AGE (In years last birthday) 36 yrs.	IF UNDER 1 YEAR Months 36 Days 36 Hours 36 Min. 36			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Texas		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Hubbard T. Bowyer				14. MOTHER'S MAIDEN NAME Virginia Wills					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: 195.0 IMMEDIATE CAUSE (a) Gram negative rod septicemia DUE TO (b) Carcinoma of the adrenal cortex with metastasis to liver and abdominal cavity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) to liver and abdominal cavity								INTERVAL BETWEEN ONSET OF DEATH 3 days 1 1/2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from February 25 19 60 to June 21 19 60 that (I) (we) lost saw the deceased alive on June 21 19 60 , and that death occurred on June 21 19 60 from the causes and on the date stated above.									
22a. SIGNATURE Gordon C. Sharp M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 6/21/60					
22c. PHYSICIAN'S NAME (Type) Gordon C. Sharp, M.D.				22d. ADDRESS The Clinical Center, NIH Bethesda 14, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 6-22-60		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City, town, or county) (State) Prince George Co., Md.			
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY ADDRESS Bethesda, Md.				25a. REC'D BY REGISTRAR JUN 22 '60 DATE		25b. REGISTRAR'S SIGNATURE Carlton S. Kraus			

020024

OFFICE OF THE ATTORNEY GENERAL

1130



RECEIVED
JAN 23 1960
U.S. DEPARTMENT OF JUSTICE
WASHINGTON, D.C.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7137 CERTIFICATE OF DEATH

07075

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY			c. LENGTH OF STAY IN 1b 14 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SANDY SPRING		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY CO. GENERAL HOSPITAL				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SAMUEL Middle BERNARD Last HILL				4. DATE OF DEATH Month JUNE Day 14 Year 19 60			
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4-11-1898		9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR: Months 6 Days 14 Hours 19 Min. 60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME SAMUEL T. HILL				14. MOTHER'S MAIDEN NAME MARY ELLEN KING			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 1		17. INFORMANT HOSPITAL RECORDS		Address OLNEY, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ③ Pulmonary emboli Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. ② Postlatic vein Thrombosis ④ Diabetes mellitus ① Pulmonary infarctions							INTERVAL BETWEEN ONSET AND DEATH 10 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) OLNEY, MARYLAND		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3 June 1960 to 14 June 1960 that (I) (we) last saw the deceased alive on 14 June 1960 and that death occurred at 2 PM , from the causes and on the date stated above.							
22a. SIGNATURE John B. Ziegler				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 14 June 60	
22c. PHYSICIAN'S NAME (Type) J. B. ZIEGLER, M. D.				22d. ADDRESS OLNEY, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/17/60	23c. NAME OF CEMETERY OR CREMATORY Sandy Spring.		23d. LOCATION (City, town, or county) (State) Sandy Spring, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Swode				ADDRESS Rockville, Md.		25a. REC'D BY REGISTRAR JUN 16 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Howard			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02075

CERTIFICATE OF DEATH

1938

Today
1938

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CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07076

7138

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>				c. LENGTH OF STAY IN 1b <i>18 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i> <i>46</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8812 Ridge Rd.</i>				d. STREET ADDRESS <i>8812 Ridge Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Ethel</i> Middle <i>Bessie</i> Last <i>HODGES</i>				4. DATE OF DEATH Month <i>June</i> Day <i>30</i> Year <i>1960</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>24 Nov. 1865</i>	
9. AGE (In years lost birth day) <i>94</i> yrs.		IF UNDER 1 YEAR Months <i>7</i> Days <i>6</i>		IF UNDER 24 HRS. Hours <i></i> Min. <i></i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>London, England</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
13. FATHER'S NAME <i>William Kirkus</i>				14. MOTHER'S MAIDEN NAME <i>Harriett Lane</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT Address <i>Mrs. Adolph Schow, 8812 Ridge Road.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>332X Congestive heart failure</i> DUE TO (b) <i>Generalized arteriosclerosis</i> Conditions; if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <i>6 years</i> DUE TO (c) <i></i>							INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Progressive cerebral thrombosis</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <i></i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <i>June 1957</i> to <i>30 June 1960</i> , that (I) last saw the deceased alive on <i>27 June 1960</i> , and that death occurred at <i>12:30 AM</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>Robert R. Belton</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>6/30/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>Robert R. Belton</i>				22d. ADDRESS <i>919 - 18th St. N.W., Washington, D.C.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>7/2/60</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Glenwood Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Washington, D. C.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>				ADDRESS <i>Bethesda, Maryland</i>		25a. REC'D BY REGISTRAR <i>JUL 5 '60</i>	
						25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

02707

CERTIFICATE OF DEATH

113



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FOR STATE
HEALTH DEPT.
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and to any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7074 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07077

1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mntg</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. LENGTH OF STAY IN 1b <u>life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Emory Grove</u>		d. STREET ADDRESS <u>1 Emory Grove</u>	
3. NAME OF DECEASED (Type or print) First <u>Carroll Wm</u> Middle <u>Howard</u> Last <u>Emory</u>		4. DATE OF DEATH <u>June 30 1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-6-1950</u>
9a. AGE (in years last birthday) <u>10</u> yrs.		9. AGE (in years last birthday) <u>10</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>school</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lawrence Howard</u>		14. MOTHER'S MAIDEN NAME <u>Lorvena E. Chambers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>1-45-100000</u>	
17. INFORMANT <u>Lawrence Howard -</u>		Address <u>Stu</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Apoplexy</u> 929.8 DUE TO <u>apoplexy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was swimming in pond & drowned</u>	
20c. TIME OF INJURY Month, Day, Year <u>2:30 p.m. 6-30-1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Pond</u>		20f. (City or town) <u>Gaithersburg</u> (County) <u>mntg</u> (State) <u>md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquest <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>6-30-60</u>	
Address (Street, city, town, or county) <u>Rockville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/3/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brooke Grove.</u>		22d. LOCATION (City, town, or county) <u>Laytonville, Md.</u> (State) <u>md</u>	
23. FUNERAL DIRECTOR <u>Robert L. Samuels</u>		ADDRESS <u>Rockville, Md.</u>	
24a. REC'D BY REGISTRAR <u>JUL 5 '60</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Kline</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7030

CERTIFICATE OF DEATH

07078

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 5 years			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 35 SILVER SPRING							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4424 Mahan Road				d. STREET ADDRESS 4424 Mahan Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last ETHEL IRENE HUDSON				4. DATE OF DEATH Month Day Year JUNE 2 19 60			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6/22/09		9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES LADY		10b. KIND OF BUSINESS OR INDUSTRY H. L. GREENE		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES SIMMONS				14. MOTHER'S MAIDEN NAME FLORENCE ELIZABETH unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 217-30-6655		17. INFORMANT Address Mr. John W. Hudson, Jr., 4424 Mahan Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 151X IMMEDIATE CAUSE (a) Carcinoma of Stomach DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 weeks							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/29/1956 to 6/2/1960 , that (I) (we) last saw the deceased alive on 5/26/1960 , and that death occurred at 6:57 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Russell B. Arnold M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/2/60	
22c. PHYSICIAN'S NAME (Type) Russell B. Arnold M.D.				22d. ADDRESS 8801 Collesville Road, Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/5/60		23c. NAME OF CEMETERY OR CREMATORY MURRANDY CEMETERY		23d. LOCATION (City, town, or county) (State) HUNTINGTOWN, CALVERT COUNTY, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska				ADDRESS SILVER SPRING, MD.		25a. REC'D BY REGISTRAR DATE JUN 9 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

1038

LIBRARY OF CONGRESS

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7055 CERTIFICATE OF DEATH

Reg. Dis. No. 07079

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hospital</u>				d. STREET ADDRESS <u>16509 Rodney Rd - Hillendale</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANK ROBERT HUSSONG</u>				4. DATE OF DEATH Month Day Year <u>JUNE 5 1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 21-1946</u>		9. AGE (In years last birthday) <u>14</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>Dr FRANK ROBERT HUSSONG</u>				14. MOTHER'S MAIDEN NAME <u>Hazel Williams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO (b) <u>Glioblastoma, left cerebral hemisphere</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>several hours</u> <u>9 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>January</u> , 19 <u>60</u> , to <u>June 5</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>June 4</u> , 19 <u>60</u> , and that death occurred at <u>6:29</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Bennet A. Porter, Jr., M.D.</u>				ADDRESS (Street, city or town, state) <u>9301 Colesville Rd., Silver Spring, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Bennet A. Porter, Jr., M.D.</u>				DATE SIGNED <u>June 5, 1960</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		22b. DATE THEREOF <u>June 7, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Thoms</u>				24a. REC'D BY REGISTRAR <u>Arthur S. Thoms</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>	
ADDRESS <u>254 Carroll St NW</u>				DATE <u>JUN 7 '60</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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7139

CERTIFICATE OF DEATH

Reg. Dist. No. 07080

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				d. STREET ADDRESS 4833 Broadbrook Drive			
3. NAME OF DECEASED (Type or print) First Louis Middle J Last Illis				4. DATE OF DEATH Month June Day 28 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 26, 1888	
9. AGE (In years lost birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Real Estate		11. BIRTHPLACE (State or foreign country) Hungary.	
12. CITIZEN OF WHAT COUNTRY? USA.							
13. FATHER'S NAME Stephen Illis.				14. MOTHER'S MAIDEN NAME ? Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) - W. War I				16. SOCIAL SECURITY NO. 137-05-4738			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MALIGNANT CACHEXIA DUE TO (c) CARCINOMA OF STOMACH				INTERVAL BETWEEN ONSET AND DEATH 48 hours 4 MONTHS 1 YEAR			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY EMPHYSEMA				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from AUG. 17 , 19 59 , to JUNE 28 , 19 60 that I last saw the deceased alive on JUNE 27 , 19 60 , and that death occurred at 3:35 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert G. Angle				ADDRESS (Street, city or town, state) 5009 Del Ray Ave Bethesda, Md			
DATE SIGNED 6/29/60							
PHYSICIAN'S NAME (Type) Robert G. Angle				5009 DelRay Ave. Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/30/60		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Rumphray				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR JUN 30 '60	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7132

CERTIFICATE OF DEATH



1. Name of deceased: [illegible]
2. Date of death: [illegible]
3. Place of death: [illegible]
4. Cause of death: [illegible]
5. Age at death: [illegible]
6. Sex: [illegible]
7. Race: [illegible]
8. Marital status: [illegible]
9. Occupation: [illegible]
10. Signature of physician: [illegible]
11. Signature of registrar: [illegible]
12. Date of registration: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7140 CERTIFICATE OF DEATH

07081

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 80 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 15		47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 5408 30th Place, NW		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ernest Middle Lee Last Jackson				4. DATE OF DEATH Month June Day 14 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 27, 1891		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Research Chemist		10b. KIND OF BUSINESS OR INDUSTRY Government (Retired)		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Benjamin F. H. Jackson				14. MOTHER'S MAIDEN NAME Martha Capps			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 203X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Multiple Myeloma DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 48 hours 3 Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 26 19 60 , to June 14 19 60 , that (I) (we) last saw the deceased alive on June 14 19 60 , and that death occurred at 8:45 PM , from the causes and on the date stated above.							
22a. SIGNATURE Charles E. Mencil M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 6-14-60	
22c. PHYSICIAN'S NAME (Type) CHARLES E. MENCIL, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/17/60		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.				25a. REC'D BY REGISTRAR DATE JUN 16 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

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CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07082

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN TB 23 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington				47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 315 12th Street, N. E.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First George Middle Henry Last JACKSON				4. DATE OF DEATH Month June Day 15 Year 19 60			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-29-08	
9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR Months 52 Days 15 Hours 19 Min. 60		IF UNDER 24 HRS. Hours 19 Min. 60			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver				10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Issac JACKSON				14. MOTHER'S MAIDEN NAME Bessie BIRD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 1943-1947				16. SOCIAL SECURITY NO. 577-07-9820		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 151X IMMEDIATE CAUSE (a) Metastatic carcinoma DUE TO (b) Carcinoma stomach DUE TO (c) 1 month Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 1 month				INTERVAL BETWEEN ONSET AND DEATH 1 month			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 11:50 am				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) physician attended the deceased from May 23 19 60 , to June 15 19 60 , that (I) xx saw the deceased alive on June 15 19 60 , and that death occurred at 11:50 am from the causes and on the date stated above.							
22a. SIGNATURE V. N. HOUK, LT, MC, USN				22b. DATE SIGNED 6-15-60			
22c. PHYSICIAN'S NAME (Type) V. N. HOUK, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-21-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Barnes & Matthews, 3619 14th St., NW, WashDC				25a. REC'D BY REGISTRAR JUN 17 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kenna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7142

CERTIFICATE OF DEATH

Reg. Dist. No. 07083

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairland		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D.		e. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First George Middle T. Last Jackson		4. DATE OF DEATH Month June Day 25 Year 1960	
5. SEX male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 8, 1891
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life or retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY general	
11. BIRTHPLACE (State or foreign country) Fairland, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George S. Jackson		14. MOTHER'S MAIDEN NAME Martha Lee	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Emory Lee Address Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremic Comma DUE TO Arteriosclerosis Cerebral Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis Renal no hypertension (c) none		INTERVAL BETWEEN ONSET AND DEATH 10 days ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 16, 1960 , to June 25, 1960 , that I last saw the deceased alive on June 24, 1960 , and that death occurred at 10:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Norbeck Rt. 1 Silver Spring DATE SIGNED 6/27/60			
ACTUAL SIGNATURE Webster Sewell		M.D. Norbeck Rt. 1 Silver Spring	
PHYSICIAN'S NAME (Type) Webster Sewell			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/28/60	
22c. NAME OF CEMETERY OR CREMATORY Round Oak Cemetery		22d. LOCATION (City, town, or county) (State) Spencerville, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden		ADDRESS Rockville Md	
24b. REC'D BY REGISTRAR DATE JUN 30 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kuma	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07084

7143

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Clarksburg</u>		c. LENGTH OF STAY IN lb <u>16 yrs</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Clarksburg</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>L.</u> Last <u>Jackson</u>				4. DATE OF DEATH Month <u>June</u> Day <u>12</u> Year <u>1968</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-18-1879</u>	9. AGE (In years as birthday) <u>88</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David Snowden</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Bowie</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Lorraine Foreman (daughter)</u> Address <u>Stn 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Chronic cardiac-renal disease</u> DUE TO (c) <u>C. A. Rt heart</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>2 mo</u> <u>1 1/2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>6-12-68</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>6/15/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Purdum,</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>6/15/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Purdum,</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>6/15/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Purdum, Md.</u>	
23. FUNERAL DIRECTOR <u>Robert L. Snowden</u> ADDRESS <u>Rookville, Md.</u>				24a. REC'D BY REGISTRAR <u>JUN 16 '60</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kins</u>	

MEDICAL CERTIFICATION

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STATE OF TEXAS
COUNTY OF DALLAS
EXAMINER'S CERTIFICATE OF DEATH

1113

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[Faint, mostly illegible text, likely a death certificate form with fields for name, age, sex, cause of death, etc.]

0/18/00

0/18/00

0/18/00

0/18/00

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7144

CERTIFICATE OF DEATH

07085

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shrine</u>		c. LENGTH OF STAY IN 1b <u>1 yr 11 mo</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brookside Grove Funeral Dir.</u>		d. STREET ADDRESS <u>7361 Fortfoote Rd. S.E.</u>	
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Johnson</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>June</u> Day <u>10</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 6, 1873</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Missionary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Yorkshire, England</u>	
11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>England</u>	
13. FATHER'S NAME <u>Henry Johnson</u>		14. MOTHER'S MAIDEN NAME <u>? Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>7361 Fortfoote Rd. S.E. Wash. D.C.</u>	
17. INFORMANT <u>Rosalie Johnson</u>		Address <u>7361 Fortfoote Rd. S.E. Wash. D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>491X</u> IMMEDIATE CAUSE (a) <u>Bilateral Broncho Pneumonia</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u> </u> DUE TO (b) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-1</u> , 19 <u>59</u> to <u>6-10</u> , 19 <u>60</u> that I last saw the deceased alive on <u>6-10</u> , 19 <u>60</u> , and that death occurred at <u>1:30</u> P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>15410 Columbia Rd</u> DATE SIGNED <u>Arthur S. Parsons</u>			
ACTUAL SIGNATURE <u>Roy B. Parsons Jr.</u> M.D.		PHYSICIAN'S NAME (Type) <u>Roy B. Parsons Jr.</u> <u>Burtonsville Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-13-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Bladensburg, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co.</u> ADDRESS <u>517-11th St. S.E.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 14 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Parsons</u>	

The authors thank A. Chelidze for her assistance in preparing the manuscript.

Received 10 January 2006; accepted 17 February 2006
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07086

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montg.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 2 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1513 East Falkland Lane				d. STREET ADDRESS 1513 East Falkland Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James Joseph Johnson				4. DATE OF DEATH June 23		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 8, 1883	
9. AGE (In years last birthday) 76 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chemist (retired)		11. BIRTHPLACE (State or foreign country) Wales		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Hilton Johnson				14. MOTHER'S MAIDEN NAME Margaret Seddon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW #1 212-01-6626		17. INFORMANT Mrs. Louise R. Johnson, 1513 E. Falkland Lane, SS			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive pulmonary hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of the lungs DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH sudden 6 mos.
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschart				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				DATE SIGNED June 23, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/27/60		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Pumphrey, INC.				24a. REC'D BY REGISTRAR DATE JUN 29 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26



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7032

CERTIFICATE OF DEATH

Reg. Dist. No. 07087

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>X</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hosp.</u>		d. STREET ADDRESS <u>18500 16 St</u>	
3. NAME OF DECEASED (Type or print) <u>Johannes Joseph Isaac Jolles</u>		4. DATE OF DEATH <u>June 22 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 16 '89</u>
9. AGE (In years lost birthday) <u>71</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Jolles</u>		14. MOTHER'S MAIDEN NAME <u>Fay Bronneman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Informant</u> Address <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure - Pneumonia</u> <u>356-1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Amphotrophic Lateral Sclerosis</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/16</u> , 19 <u>59</u> , to <u>6/22</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>6/22</u> , 19 <u>60</u> , and that death occurred at <u>2:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7733 Alaska Ave. N.W. Washington 12-D.C.</u> DATE SIGNED <u>6/22/60</u>			
ACTUAL SIGNATURE <u>Benjamin Isaacson</u>		M.D. <u>7733 Alaska Ave. N.W. Washington 12-D.C.</u>	
PHYSICIAN'S NAME (Type) <u>Benjamin Isaacson, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6-23-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BNAI ISRAEL CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>OXON HILL MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Danzansky</u>		ADDRESS <u>Wash DC</u>	
24a. REC'D BY REGISTRAR <u>JUN 24 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11003

CERTIFICATE OF DEATH

1053



X



[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "Name", "Age", "Sex", "Cause of Death", and "Date" are faintly visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7033

CERTIFICATE OF DEATH

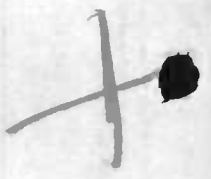
07088

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 6 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 12,310 Brookhaven Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Walker Jones		4. DATE OF DEATH June 11, 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 19, 1869
9. AGE (In years lost birthday) 90 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (retired) Cranesman		11b. KIND OF BUSINESS OR INDUSTRY B. & O. Railroad	
11c. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Findlay Jones		14. MOTHER'S MAIDEN NAME Sadie Connors	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 705-03-1683	
17. INFORMANT William J. Jones, son, 12,310 Brookhaven Drive,		Address: Silver Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic arteriosclerotic heart disease (c) Generalized marked arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 4 days undetermined undetermined	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JAN 1957 to 11 JUN 1960 , that (I) (we) last saw the deceased alive on 9 JUN 1960 , and that death occurred at 10 P M, from the causes and on the date stated above.			
22a. SIGNATURE L. Marshall Cuvillier, Jr. M.D.		22b. DATE SIGNED 6/12/60	
22c. PHYSICIAN'S NAME (Type) L. Marshall Cuvillier, Jr.		22d. ADDRESS 1407 Woodside Parkway, Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 16, 1960	
23c. NAME OF CEMETERY OR CREMATORY Spring Hill		23d. LOCATION (City, town, or county) (State) Shippensburg, Cumberland, Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE WABNER E. PUMPHREY, INC. Edmond A. Jahn		25a. REC'D BY REGISTRAR DATE JUN 17 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

07008

CERTIFICATE

1033



7087

CERTIFICATE OF DEATH

07089

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5704 Randolph Road		d. STREET ADDRESS 5704 Randolph Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle PARK Last KEISER		4. DATE OF DEATH Month June Day 30 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 3, 1877
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.-Carpenter		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Cyrus Keiser		14. MOTHER'S MAIDEN NAME Elizabeth Sweeter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Louise P. Keiser-Item# 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Atherosclerosis DUE TO (c) Generalized Atherosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/10 , 19 60 , to 6/30 , 19 60 , that I last saw the deceased alive on 6/29/60 , 19 60 , and that death occurred at 10 A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE W. T. Joyce		ADDRESS (Street, city or town, state) Bethesda, Md. DATE SIGNED 7/1/60	
PHYSICIAN'S NAME (Type) W. T. Joyce		8106 Maple Ridge Rd., Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	7/2/60	Mt. Zion	Bethesda, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler		ADDRESS 1331 E. Montg. Ave. Rockville, Md.	
24a. REC'D BY REGISTRAR JUL 5 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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03080

CERTIFICATE OF BIRTH

1905

[Faint, mostly illegible text and lines on a birth certificate form. The form includes fields for name, date, and location, with some handwritten entries visible.]

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C 51

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07090

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 5 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		d. STREET ADDRESS Rt. #2, Box 115	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Harold Middle Bruce Last KILMER III		4. DATE OF DEATH Month June Day 15 Year 19 60	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-15-60
9. AGE (In years lost birthday) yrs. 14		IF UNDER 1 YEAR Months 14 Days 55 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Maryland - Ches. Co.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harold Bruce KILMER, JR.		14. MOTHER'S MAIDEN NAME Audrey Jean BLACKBURN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (F) Harold B. Kilmer, Jr., same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) NEONATAL ATELECTASIS DUE TO (b) IMMATURITY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that X (this hospital) attended the deceased from June 15, 1960 to June 15, 1960 , that X (we) last saw the deceased alive on June 15, 1960 , and that death occurred at 8:55 pm , from the causes and on the date stated above.			
22a. SIGNATURE Fred W. Grello		22b. DATE SIGNED 6-16-60	
22c. PHYSICIAN'S NAME (Type) Fred W. GRELLO, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-20-60	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co., 3072 M St., NW, Washington, DC		25a. REC'D BY REGISTRAR JUN 20 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

2066191XV1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7088

CERTIFICATE OF DEATH

07091

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				c. LENGTH OF STAY IN 1b 10 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION #8 Sedgewick Lane				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Anna Middle Daisy Last King				4. DATE OF DEATH Month June Day 1 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/22/1880	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 5 Days 9		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME Peter Wright				14. MOTHER'S MAIDEN NAME Dugan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Mrs. Pauline Neville-daughter-same 2d	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition DUE TO 790.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 3 19 58 to May 30 19 60 that (I) (we) last saw the deceased alive and well on May 30 19 60 , and that death occurred at 11:30AM on June 1, 1960 from the causes and on the date stated above.							
22a. SIGNATURE Alfred S. Norton				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/1/60	
22c. PHYSICIAN'S NAME (Type) Alfred S. Norton M.D.				22d. ADDRESS 4711 Highland Ave. Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/4/60		23c. NAME OF CEMETERY OR CREMATORY Wash. Nat. Mem. Park		23d. LOCATION (City, town, or county) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE JUN 8 '60	
				25b. REGISTRAR'S SIGNATURE Arthur L. House			

X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

7146
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 1 Film G2645 6-20-60 et
CERTIFICATE OF DEATH

07092
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montg MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poolesville. Rural		c. LENGTH OF STAY IN 1b 3Mo	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 0717 Cedar Ave. Gaithersburg		d. STREET ADDRESS Maryland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Partnership Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ellillian Middle Gertrude Last King		4. DATE OF DEATH Month June Day 13 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar 24-1887
9. AGE (In years last birthday) yrs. 73		IF UNDER 1 YEAR Months 2 Days 19	
IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY HouseKeeping	
11. BIRTHPLACE (State or foreign country) Montg, Co. Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James Larman		14. MOTHER'S MAIDEN NAME Elizabeth M Thompson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 		16. SOCIAL SECURITY NO. 	
INFORMANT Anna M. MorningStar. Dickerson-Md.		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anemia, Secondary, Chronic Blood Loss DUE TO 581.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Rupture of Varices of Esophagus DUE TO Cirrhosis of liver (c) 		INTERVAL BETWEEN ONSET AND DEATH 3 weeks 3 weeks 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 13, 1950 , to June 13, 1960 , that I last saw the deceased alive on June 13, 1960 , and that death occurred at 2:55 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Barnesville, Md. DATE SIGNED June 13, 1960 ACTUAL SIGNATURE Gordon M. Smith M.D. Gordon M. Smith PHYSICIAN'S NAME (Type) Gordon M. Smith			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-15-60	
22c. NAME OF CEMETERY OR CREMATORY St Rose.		22d. LOCATION (City, town, or county) (State) Clopper. Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner. Gaithersburg. Md.		24a. REC'D BY REGISTRAR DATE JUN 15 '60	
24b. REGISTRAR'S SIGNATURE Charles S. Finner			

70

1146

CENTRAL OF DEATH

07002

IV Cedar Ave. Minneapolis
Minn. 55405

White
Mar 24-1987

Housekeeping, North St. Minn.
Minneapolis, Minnesota

James H. Henningsen, District Atty.
Minneapolis, Minnesota

James H. Henningsen, District Atty.
Minneapolis, Minnesota

James H. Henningsen, District Atty.
Minneapolis, Minnesota

James H. Henningsen, District Atty.
Minneapolis, Minnesota

James H. Henningsen, District Atty.
Minneapolis, Minnesota

James H. Henningsen, District Atty.
Minneapolis, Minnesota

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7147

CERTIFICATE OF DEATH

07093
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>70 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mount Morris</u>		75X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>Box 262</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ralph</u> Middle <u>Scott</u> Last <u>King</u>				4. DATE OF DEATH Month <u>June</u> Day <u>4</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 23, 1919</u>		9. AGE (In years last birthday) <u>41</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Paul King</u>				14. MOTHER'S MAIDEN NAME <u>Jeanne Hickman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> <u>195.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pinealoma brain tumor</u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u> <u>2 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u> </u> Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>				20g. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>			
21. I certify that I attended the deceased from <u>March 26</u> , 19 <u>60</u> , to <u>June 4</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>June 4</u> , 19 <u>60</u> , and that death occurred at <u>6:15 P</u> .M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				M.D. <u>The Clinical Center</u> DATE SIGNED <u>6/5/60</u>			
PHYSICIAN'S NAME (Type) <u>FRANCIS L. MERRITT, M.D.</u>				<u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-7-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Summit</u>		22d. LOCATION (City, town, or county) (State) <u>Mount Morris Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>				ADDRESS <u>7557 The Ave. 2nd</u>		24. REC'D BY REGISTRAR DATE <u>JUN 8 60</u>	
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				24c. REGISTRAR'S NAME <u>William S. House</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

1917

DATE OF DEATH
1917

TIME OF DEATH
1917

PLACE OF DEATH
1917

CAUSE OF DEATH
1917

PLACE OF BIRTH
1917

DATE OF BIRTH
1917

PLACE OF BIRTH
1917

DATE OF BIRTH
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PLACE OF BIRTH
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DATE OF BIRTH
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DATE OF BIRTH
1917

PLACE OF BIRTH
1917

1-7-10

1917

1917

1917

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07094

7148

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Washington, D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 52 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Dudley Wright KNOX		4. DATE OF DEATH Month JUNE Day 11 Year 19 60	
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 June 1877
9. AGE (In years last birthday) yrs. 82		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Naval Officer		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
11. BIRTHPLACE (State or foreign country) WASHINGTON		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Thomas T. KNOX		14. MOTHER'S MAIDEN NAME Cornilla GRASSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I 1922	
17. INFORMANT HOSP. RECORDS		Address	
18. CAUSE OF DEATH [Enter only one cause per time for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of bladder DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastasis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 20 19 60 , to June 11 19 60 , that (I) (we) last saw the deceased alive on June 10 19 60 , and that death occurred at 6:45 AM , from the causes and on the date stated above.			
22a. SIGNATURE Richard E. Akers M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 6-11-60	
22c. PHYSICIAN'S NAME (Type) Richard E. AKERS LT MC USN		22d. ADDRESS U.S. Naval Hospital, NNMC, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremat. 6-13-60		23b. DATE THEREOF 6-13-60	
23c. NAME OF BURIAL OR CREMATION PLACE Cedar Hill Cemetery		23d. LOCATION (City or town) (County) (State) Suitland Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. GAWLER'S & SON		25a. REC'D BY REGISTRAR JUN 14 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kneiss			

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12. 101-102-103-104-105-106-107-108-109-110-111-112-113-114-115-116-117-118-119-120-121-122-123-124-125-126-127-128-129-130-131-132-133-134-135-136-137-138-139-140-141-142-143-144-145-146-147-148-149-150-151-152-153-154-155-156-157-158-159-160-161-162-163-164-165-166-167-168-169-170-171-172-173-174-175-176-177-178-179-180-181-182-183-184-185-186-187-188-189-190-191-192-193-194-195-196-197-198-199-200-201-202-203-204-205-206-207-208-209-210-211-212-213-214-215-216-217-218-219-220-221-222-223-224-225-226-227-228-229-230-231-232-233-234-235-236-237-238-239-240-241-242-243-244-245-246-247-248-249-250-251-252-253-254-255-256-257-258-259-260-261-262-263-264-265-266-267-268-269-270-271-272-273-274-275-276-277-278-279-280-281-282-283-284-285-286-287-288-289-290-291-292-293-294-295-296-297-298-299-300-301-302-303-304-305-306-307-308-309-310-311-312-313-314-315-316-317-318-319-320-321-322-323-324-325-326-327-328-329-330-331-332-333-334-335-336-337-338-339-340-341-342-343-344-345-346-347-348-349-350-351-352-353-354-355-356-357-358-359-360-361-362-363-364-365-366-367-368-369-370-371-372-373-374-375-376-377-378-379-380-381-382-383-384-385-386-387-388-389-390-391-392-393-394-395-396-397-398-399-400-401-402-403-404-405-406-407-408-409-410-411-412-413-414-415-416-417-418-419-420-421-422-423-424-425-426-427-428-429-430-431-432-433-434-435-436-437-438-439-440-441-442-443-444-445-446-447-448-449-450-451-452-453-454-455-456-457-458-459-460-461-462-463-464-465-466-467-468-469-470-471-472-473-474-475-476-477-478-479-480-481-482-483-484-485-486-487-488-489-490-491-492-493-494-495-496-497-498-499-500-501-502-503-504-505-506-507-508-509-510-511-512-513-514-515-516-517-518-519-520-521-522-523-524-525-526-527-528-529-530-531-532-533-534-535-536-537-538-539-540-541-542-543-544-545-546-547-548-549-550-551-552-553-554-555-556-557-558-559-560-561-562-563-564-565-566-567-568-569-570-571-572-573-574-575-576-577-578-579-580-581-582-583-584-585-586-587-588-589-590-591-592-593-594-595-596-597-598-599-600-601-602-603-604-605-606-607-608-609-610-611-612-613-614-615-616-617-618-619-620-621-622-623-624-625-626-627-628-629-630-631-632-633-634-635-636-637-638-639-640-641-642-643-644-645-646-647-648-649-650-651-652-653-654-655-656-657-658-659-660-661-662-663-664-665-666-667-668-669-670-671-672-673-674-675-676-677-678-679-680-681-682-683-684-685-686-687-688-689-690-691-692-693-694-695-696-697-698-699-700-701-702-703-704-705-706-707-708-709-710-711-712-713-714-715-716-717-718-719-720-721-722-723-724-725-726-727-728-729-730-731-732-733-734-735-736-737-738-739-740-741-742-743-744-745-746-747-748-749-750-751-752-753-754-755-756-757-758-759-760-761-762-763-764-765-766-767-768-769-770-771-772-773-774-775-776-777-778-779-780-781-782-783-784-785-786-787-788-789-790-791-792-793-794-795-796-797-798-799-800-801-802-803-804-805-806-807-808-809-810-811-812-813-814-815-816-817-818-819-820-821-822-823-824-825-826-827-828-829-830-831-832-833-834-835-836-837-838-839-840-841-842-843-844-845-846-847-848-849-850-851-852-853-854-855-856-857-858-859-860-861-862-863-864-865-866-867-868-869-870-871-872-873-874-875-876-877-878-879-880-881-882-883-884-885-886-887-888-889-890-891-892-893-894-895-896-897-898-899-900-901-902-903-904-905-906-907-908-909-910-911-912-913-914-915-916-917-918-919-920-921-922-923-924-925-926-927-928-929-930-931-932-933-934-935-936-937-938-939-940-941-942-943-944-945-946-947-948-949-950-951-952-953-954-955-956-957-958-959-960-961-962-963-964-965-966-967-968-969-970-971-972-973-974-975-976-977-978-979-980-981-982-983-984-985-986-987-988-989-990-991-992-993-994-995-996-997-998-999-1000-1001-1002-1003-1004-1005-1006-1007-1008-1009-1010-1011-1012-1013-1014-1015-1016-1017-1018-1019-1020-1021-1022-1023-1024-1025-1026-1027-1028-1029-1030-1031-1032-1033-1034-1035-1036-1037-1038-1039-1040-1041-1042-1043-1044-1045-1046-1047-1048-1049-1050-1051-1052-1053-1054-1055-1056-1057-1058-1059-1060-1061-1062-1063-1064-1065-1066-1067-1068-1069-1070-1071-1072-1073-1074-1075-1076-1077-1078-1079-1080-1081-1082-1083-1084-1085-1086-1087-1088-1089-1090-1091-1092-1093-1094-1095-1096-1097-1098

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7149

CERTIFICATE OF DEATH

07095

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FAIRLAND</u>		c. LENGTH OF STAY IN 1b <u>5/14-6/6/60</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		1656.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>FAIRLAND-NURSING Home</u>		d. STREET ADDRESS <u>8110-New Hampshire Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>HORNHAUSER</u> Last <u></u>		4. DATE OF DEATH Month <u>6</u> Day <u>6</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 10-1892</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Max Zucker</u>		14. MOTHER'S MAIDEN NAME <u>MARY STERNHEIM</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u></u>	
INFORMANT <u>Nursing Home Record</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Angiopathic Lateral Sclerosis</u> 356.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>January 1960</u> , to <u>June 6, 1960</u> , that I last saw the deceased alive on <u>June 4, 1960</u> , and that death occurred at <u>11:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Boris Rabkin</u>		ADDRESS (Street, city or town, state) <u>1019 University Boulevard</u>	
PHYSICIAN'S NAME (Type) <u>BORIS RABKIN, M.D.</u>		DATE SIGNED <u>6/6/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/9/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New York, N.Y.</u>		22d. LOCATION (City, town, or county) (State) <u>New York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Nanyansky & Sons</u>		24a. REC'D BY REGISTRAR <u>3501-14th St. N.W.</u>	
ADDRESS <u>Wash. D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WILLIAM J. HARRIS
Age 72 years
Born at New York City, N.Y.
Died at New York City, N.Y.
Cause of death: Heart failure
Date of death: May 10, 1913
Place of death: New York City, N.Y.
Buried at: New York City, N.Y.

X

Witnessed and attested:
J. H. HARRIS
J. H. HARRIS
J. H. HARRIS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07096

7150

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 12 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Turkey b. COUNTY Ankara c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 15X-1 d. STREET ADDRESS Evkaf Apartment 2, Kapi # 10 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Adil Middle (None) Last Kursad		4. DATE OF DEATH Month June Day 13 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1, 1914
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Government Officer		10b. KIND OF BUSINESS OR INDUSTRY Government	11. BIRTHPLACE (State or foreign country) Turkey
12. CITIZEN OF WHAT COUNTRY? Turkey		13. FATHER'S NAME Akif Kursad	
14. MOTHER'S MAIDEN NAME Fatma Eren		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular failure DUE TO (b) Mitral insufficiency DUE TO (c) Rheumatic heart disease INTERVAL BETWEEN ONSET AND DEATH 27 years 30 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1 19 60 to June 13 19 60 , that (I) (we) last saw the deceased alive on June 13 19 60 , and that death occurred at 4:30 AM from the causes and on the date stated above.			
22a. SIGNATURE E. Kent Carney 22c. PHYSICIAN'S NAME (Type) E. Kent Carney, M.D.		22b. DATE SIGNED 6/18/60 22d. ADDRESS The Clinical Center Maryland National Institutes of Health, Bethesda 14	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/24/60	
23c. NAME OF CEMETERY OR CREMATORY Ankara, Turkey		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. Inc. 3072 M. St. N. W. Wash. D. C.		25a. REC'D BY REGISTRAR JUN 20 '60 25b. REGISTRAR'S SIGNATURE Charles L. Hume	

03000

CERTIFICATE OF DEATH

1120



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7034

CERTIFICATE OF DEATH

Reg. Dist. No.

07097

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 9 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 12,208 EDMONT STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Dorothy M Landvoigt		4. DATE OF DEATH Month June Day 2 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1, 1914
9. AGE (In years last birthday) 46 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk - Posting Sect.		10b. KIND OF BUSINESS OR INDUSTRY F.B.I., U.S. Gov't	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE R. McGEE		14. MOTHER'S MAIDEN NAME MAE LINQUIST	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mr. Carroll D. Landvoigt, 12,208 Edgemont St.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis involving both lungs and abdominal viscera DUE TO Primary Carcinoma right breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 20 w/o (c) 170X INTERVAL BETWEEN ONSET AND DEATH 20 w/o			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Silver Spring Md			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While Not while of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 10, 1959 to June 2, 1960 , that I last saw the deceased alive on June 1, 1960 , and that death occurred at 5:20 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10620 Georgia Ave Silver Spring Md DATE SIGNED June 2, 1960			
ACTUAL SIGNATURE George L Ball M.D.		PHYSICIAN'S NAME (Type) George L Ball	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/6/60	
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Ziska		24a. REC'D BY REGISTRAR DATE JUN 9 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Knease			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

34

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES M. JONES		2. SEX Male		3. AGE 35	
4. DATE OF DEATH JAN 15 1968		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH HOME	
7. CAUSE OF DEATH HEART DISEASE		8. MANNER OF DEATH NATURAL		9. SIGNATURE OF PHYSICIAN J. M. JONES	
10. SIGNATURE OF REGISTRAR J. M. JONES		11. SIGNATURE OF WITNESS J. M. JONES		12. SIGNATURE OF DECEASED J. M. JONES	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7151

07098

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 4 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WOODBINE		d. STREET ADDRESS ROUTE #2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DAISY Middle IONA Last LEAKINS		4. DATE OF DEATH Month JUNE Day 9 Year 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 23, 1902
9. AGE (In years lost birthday) yrs. 57		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JAMES AUTHUR MOXLEY		14. MOTHER'S MAIDEN NAME HATTIE VIRGINIA Easton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT HOSPITAL RECORDS		Address OLNEY, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Chronic Nephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH 3 wks. 7 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/5 to 6/9 19 60 that (I) (we) last saw the deceased alive on 6/9 19 60 , and that death occurred at 4:00 P. M, from the causes and on the date stated above.			
22a. SIGNATURE C. H. LIGON, MD.		22b. DATE SIGNED 6/10/60	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS SANDY SPRING, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 12, 1960	
23c. NAME OF CEMETERY OR CREMATORY Pine Grove		23d. LOCATION (City, town, or county) (State) Mt. Airy, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Olin L. Moleworth		25a. REC'D BY REGISTRAR DATE JUN 14 '60	
ADDRESS Damascus, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7152

CERTIFICATE OF DEATH

07099

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b 6 HRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CONNIE Middle LOUISE Last LEWIS				4. DATE OF DEATH Month JUNE Day 28 Year 19 60			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/21/57	
9. AGE (In years last birthday) 2 yrs.		IF UNDER 1 YEAR Months 2 Days 28 Hours 19 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME JAMES ALEXANDER LEWIS				14. MOTHER'S MAIDEN NAME CARA GROSS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT HOSPITAL RECORDS, OLNEY, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia 490X DUE TO (b) Multiple pulmonary Infarctions Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Intestinal Obstruction due to Parasites							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/28 19 60 , to 6/28 19 60 , that (I) (we) last saw the deceased alive on 6/28 19 60 and that death occurred at 11 AM , from the causes and on the date stated above.							
22a. SIGNATURE A. D. Bonifant				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/28/60	
22c. PHYSICIAN'S NAME (Type) A. D. BONIFANT, M. D.				22d. ADDRESS SANDY SPRING, MARYLAND			
23a. BURIAL, CREMATION, or MOVING (Specify) Burial		23b. DATE THEREOF June 30 1960		23c. NAME OF CEMETERY OR CREMATORY Laytonsville		23d. LOCATION (City, town, or county) (State) Laytonsville Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Baker				ADDRESS Laytonsville, Md.		25a. REC'D BY REGISTRAR JUL 1 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

1152

CERTIFICATE OF DEATH

DATE OF DEATH

TIME

PLACE OF DEATH

SEX

RACE

AGE

EDUCATION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

MANNER OF DEATH

HOSPITAL RECORDS

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

SEX

RACE

AGE

VS A1S (4)
ISM 9/S8

03100

CERTIFICATE OF DEATH

1986

50

[Faint, mostly illegible text from a death certificate form, including fields for name, date of birth, date of death, and cause of death.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7153
CERTIFICATE OF DEATH

07101

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 26 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5120 Manning Dr.		/d. STREET ADDRESS 5120 Manning Dr.	
3. NAME OF DECEASED (Type or print) First SIDNEY Middle ELY Last LINDERMAN		4. DATE OF DEATH Month June Day 10 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 20, 1903
9. AGE (In years lost birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Exec. Vice Chairman Retired		10b. KIND OF BUSINESS OR INDUSTRY Cast Iron Pressure Pipe Inst.	
11. BIRTHPLACE (State or foreign country) Bethlehem, Penna.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Garrett Brodhead Linderman		14. MOTHER'S MAIDEN NAME Jennie Brodhead	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-09-0468	
17. INFORMANT Wife		Address Same as Item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 692.6 Acute toxic myocarditis DUE TO (b) Right perinephritic abscess DUE TO (c) unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 18 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) cirrhosis of liver; hepatic insufficiency		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from Feb. 1959 to June 1960 , that (I) (we) last saw the deceased alive on June 8 1960 , and that death occurred at 1 A M, from the causes and on the date stated above.			
22a. SIGNATURE Robert N. Coale		22b. DATE SIGNED 6/10/60	
22c. PHYSICIAN'S NAME (Type) ROBERT N. COALE		22d. ADDRESS 4630 Montgomery Ave, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 6-11-60	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION (City, town, or county) (State) Prince George Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY,		25a. REC'D BY REGISTRAR DATE JUN 14 '60	
ADDRESS Bethesda, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Evans	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7035

CERTIFICATE OF DEATH

Reg. Dist. No.

02102

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 9 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8411 11th Ave.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 20 SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8411 11th Ave.		d. STREET ADDRESS 1 8411 11th Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First SMITH Middle (NMI) Last LINTHICUM		4. DATE OF DEATH Month JUNE Day 20 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/13/93
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) District Mgr.		10b. KIND OF BUSINESS OR INDUSTRY Wilson Steamboat Line	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE F. LINTHICUM		14. MOTHER'S MAIDEN NAME LAURA TABLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 578-14-6584	
17. INFORMANT Mrs. Marie W. Linthicum, 8411 11th Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Artery Heart Disease DUE TO (c) Coronary Sclerosis INTERVAL BETWEEN ONSET AND DEATH 2-3 minutes 4-5 yrs. 4-5 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept , 1957, to June , 1960, that I last saw the deceased alive on JUNE 20 , 1960, and that death occurred at 8:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert B. Irey		ADDRESS (Street, city or town, state) 7105 Riggs Rd	
PHYSICIAN'S NAME (Type) ROBERT B. IREY		DATE SIGNED 6-20-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/23/60	
22c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WALTER E. PUMPHREY, INC.		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR DATE JUN 24 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Farnes	

1038

CERTIFICATE OF DEATH

1038

1. NAME OF DECEASED JOHN J. ROBERTS		2. SEX Male		3. AGE 45		4. DATE OF BIRTH 10/15/1893		5. PLACE OF BIRTH BALTIMORE, MARYLAND	
6. OCCUPATION Carpenter		7. MARITAL STATUS Married		8. EDUCATION High School		9. RELIGION Roman Catholic		10. RACE White	
11. CAUSE OF DEATH Heart Disease		12. MANNER OF DEATH Natural		13. PERIOD OF ILLNESS 2 weeks		14. PLACE OF DEATH Home		15. TIME OF DEATH 10:30 AM	
16. SIGNATURE OF PHYSICIAN J. J. ROBERTS		17. SIGNATURE OF WITNESSES J. J. ROBERTS		18. SIGNATURE OF DECEASED J. J. ROBERTS		19. SIGNATURE OF FUNERAL HOME J. J. ROBERTS		20. SIGNATURE OF CLERK J. J. ROBERTS	
21. DATE OF DEATH 10/20/1938		22. TIME OF DEATH 10:30 AM		23. PLACE OF DEATH Home		24. SIGNATURE OF DECEASED J. J. ROBERTS		25. SIGNATURE OF FUNERAL HOME J. J. ROBERTS	
26. SIGNATURE OF CLERK J. J. ROBERTS		27. SIGNATURE OF DECEASED J. J. ROBERTS		28. SIGNATURE OF FUNERAL HOME J. J. ROBERTS		29. SIGNATURE OF CLERK J. J. ROBERTS		30. SIGNATURE OF DECEASED J. J. ROBERTS	
31. SIGNATURE OF FUNERAL HOME J. J. ROBERTS		32. SIGNATURE OF CLERK J. J. ROBERTS		33. SIGNATURE OF DECEASED J. J. ROBERTS		34. SIGNATURE OF FUNERAL HOME J. J. ROBERTS		35. SIGNATURE OF CLERK J. J. ROBERTS	
36. SIGNATURE OF DECEASED J. J. ROBERTS		37. SIGNATURE OF FUNERAL HOME J. J. ROBERTS		38. SIGNATURE OF CLERK J. J. ROBERTS		39. SIGNATURE OF DECEASED J. J. ROBERTS		40. SIGNATURE OF FUNERAL HOME J. J. ROBERTS	
41. SIGNATURE OF CLERK J. J. ROBERTS		42. SIGNATURE OF DECEASED J. J. ROBERTS		43. SIGNATURE OF FUNERAL HOME J. J. ROBERTS		44. SIGNATURE OF CLERK J. J. ROBERTS		45. SIGNATURE OF DECEASED J. J. ROBERTS	
46. SIGNATURE OF FUNERAL HOME J. J. ROBERTS		47. SIGNATURE OF CLERK J. J. ROBERTS		48. SIGNATURE OF DECEASED J. J. ROBERTS		49. SIGNATURE OF FUNERAL HOME J. J. ROBERTS		50. SIGNATURE OF CLERK J. J. ROBERTS	
51. SIGNATURE OF DECEASED J. J. ROBERTS		52. SIGNATURE OF FUNERAL HOME J. J. ROBERTS		53. SIGNATURE OF CLERK J. J. ROBERTS		54. SIGNATURE OF DECEASED J. J. ROBERTS		55. SIGNATURE OF FUNERAL HOME J. J. ROBERTS	
56. SIGNATURE OF CLERK J. J. ROBERTS		57. SIGNATURE OF DECEASED J. J. ROBERTS		58. SIGNATURE OF FUNERAL HOME J. J. ROBERTS		59. SIGNATURE OF CLERK J. J. ROBERTS		60. SIGNATURE OF DECEASED J. J. ROBERTS	
61. SIGNATURE OF FUNERAL HOME J. J. ROBERTS		62. SIGNATURE OF CLERK J. J. ROBERTS		63. SIGNATURE OF DECEASED J. J. ROBERTS		64. SIGNATURE OF FUNERAL HOME J. J. ROBERTS		65. SIGNATURE OF CLERK J. J. ROBERTS	
66. SIGNATURE OF DECEASED J. J. ROBERTS		67. SIGNATURE OF FUNERAL HOME J. J. ROBERTS		68. SIGNATURE OF CLERK J. J. ROBERTS		69. SIGNATURE OF DECEASED J. J. ROBERTS		70. SIGNATURE OF FUNERAL HOME J. J. ROBERTS	
71. SIGNATURE OF CLERK J. J. ROBERTS		72. SIGNATURE OF DECEASED J. J. ROBERTS		73. SIGNATURE OF FUNERAL HOME J. J. ROBERTS		74. SIGNATURE OF CLERK J. J. ROBERTS		75. SIGNATURE OF DECEASED J. J. ROBERTS	
76. SIGNATURE OF FUNERAL HOME J. J. ROBERTS		77. SIGNATURE OF CLERK J. J. ROBERTS		78. SIGNATURE OF DECEASED J. J. ROBERTS		79. SIGNATURE OF FUNERAL HOME J. J. ROBERTS		80. SIGNATURE OF CLERK J. J. ROBERTS	
81. SIGNATURE OF DECEASED J. J. ROBERTS		82. SIGNATURE OF FUNERAL HOME J. J. ROBERTS		83. SIGNATURE OF CLERK J. J. ROBERTS		84. SIGNATURE OF DECEASED J. J. ROBERTS		85. SIGNATURE OF FUNERAL HOME J. J. ROBERTS	
86. SIGNATURE OF CLERK J. J. ROBERTS		87. SIGNATURE OF DECEASED J. J. ROBERTS		88. SIGNATURE OF FUNERAL HOME J. J. ROBERTS		89. SIGNATURE OF CLERK J. J. ROBERTS		90. SIGNATURE OF DECEASED J. J. ROBERTS	
91. SIGNATURE OF FUNERAL HOME J. J. ROBERTS		92. SIGNATURE OF CLERK J. J. ROBERTS		93. SIGNATURE OF DECEASED J. J. ROBERTS		94. SIGNATURE OF FUNERAL HOME J. J. ROBERTS		95. SIGNATURE OF CLERK J. J. ROBERTS	
96. SIGNATURE OF DECEASED J. J. ROBERTS		97. SIGNATURE OF FUNERAL HOME J. J. ROBERTS		98. SIGNATURE OF CLERK J. J. ROBERTS		99. SIGNATURE OF DECEASED J. J. ROBERTS		100. SIGNATURE OF FUNERAL HOME J. J. ROBERTS	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7057 CERTIFICATE OF DEATH

07103

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN 1b <u>YRS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7302 HOLLY AVE.</u>		d. STREET ADDRESS <u>7302 HOLLY AVENUE</u>	
3. NAME OF DECEASED (Type or print) First <u>FRED</u> Middle <u>B.</u> Last <u>LINTON</u>		4. DATE OF DEATH Month <u>June</u> Day <u>19</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 14, 1895</u>
9. AGE (In years lost birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>5</u> Hours <u>15</u> Min.	11. IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET. U.S. GOVT.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FOOD & DRUG ADM.</u>	
11. BIRTHPLACE (State, or foreign country) <u>PA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>NOT AVAILABLE</u>		14. MOTHER'S MAIDEN NAME <u>BUFFINGTON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS MAYRIE CLEAVER LINTON</u>		Address <u>7302 HOLLY AVE TAKOMA PARK, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-sclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 wks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 2, 1960</u> to <u>June 19, 1960</u> , that (I) (we) last saw the deceased alive on <u>June 18, 1960</u> , and that death occurred at <u>1:38 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>A. B. Little</u> M.D.		22b. DATE SIGNED _____	
22c. PHYSICIAN'S NAME (Type) <u>A. B. LITTLE MD</u>		22d. ADDRESS <u>6911 5TH ST. N.W.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>JUNE 22, '60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>TAYLORS CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>NR. CENTERTVILLE, WASH. CO., PA.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Hume</u>		25a. REC'D BY REGISTRAR <u>DATE JUN 21 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>		25c. ADDRESS <u>254 BARROLL ST. N.W. DC</u>	

07108

CERTIFICATE OF DEATH

1027

81

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7154

CERTIFICATE OF DEATH

Reg. Dist. No.

07104

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>Massapequa</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Massapequa</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>66 Cedar Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Antonio</u> Middle <u>(None)</u> Last <u>Livorno</u>				4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 25, 1892</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>68</u> Days <u>68</u> Hours <u>68</u> Min. <u>68</u>		IF UNDER 24 HRS. Months <u>68</u> Days <u>68</u> Hours <u>68</u> Min. <u>68</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clothing Manufacturer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Manufacturing</u>			
11. BIRTHPLACE (State or foreign country) <u>Italy</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>(Unknown) Livorno</u>				14. MOTHER'S MAIDEN NAME <u>(Unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW I</u>				16. SOCIAL SECURITY NO. <u>Unascertainable</u>			
17. INFORMANT <u>The Medical Record</u>				Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>421.4</u> IMMEDIATE CAUSE (a) <u>? Cardiac Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Uremia</u> DUE TO (c) <u>Candida Endocarditis</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 Months</u> <u>6 Months</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Brooklyn</u>				20g. (County) <u>Brooklyn</u>		20h. (State) <u>N.Y.</u>	
21. I certify that I attended the deceased from <u>May 17</u> , 19 <u>60</u> , to <u>June 3</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>June 3</u> , 19 <u>60</u> , and that death occurred at <u>2:25A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>6-3-60</u>							
ACTUAL SIGNATURE <u>Steven Schenker</u>				PHYSICIAN'S NAME (Type) <u>STEVEN SCHENKER, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>6-4-1960</u>				22b. DATE THEREOF <u>6-4-1960</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>St Johns Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Brooklyn</u> <u>N.Y.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co</u>				24a. RECEIVED BY REGISTRAR DATE <u>JUN 8 '60</u>			
24b. REGISTRAR'S SIGNATURE <u>Anthony S. Thomas</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7058

CERTIFICATE OF DEATH

Reg. Dist. No.

07105

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b 5 Hours.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Long		4. DATE OF DEATH Month Day Year June 5 19 60	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5, 1960
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) yrs. Months Days Hours Min. 5 - - - -	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Charles Leonard Long		12. CITIZEN OF WHAT COUNTRY? United States	
14. MOTHER'S MAIDEN NAME Vivian Audrey Martin		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO.		17. INFORMANT mother Address same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 5, 1960 to 10:45am, June 5, 1960 , that I last saw the deceased alive on June 5, 1960 , and that death occurred at 10:45am , from the causes and on the date stated above.			
ACTUAL SIGNATURE Herbert H. Diamond		ADDRESS (Street, city or town, state) 8224 Georgia Avenue, Silver Spring, Md.	
PHYSICIAN'S NAME (Type) Herbert H. Diamond, M.D.,		DATE SIGNED 6/5/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) cremation		22b. DATE THEREOF 6-6-60	
22c. NAME OF CEMETERY OR CREMATORY Wash. San. & Hosp.		22d. LOCATION (City, town, or county) (State) Takoma Park Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert Hare, M.D., Wash. San. & Hosp.		24a. REC'D BY REGISTRAR DATE JUN 14 '60	
		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

VS A15 (4)
15M 10/57

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7155

CERTIFICATE OF DEATH

07106

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 10 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mildred Middle Mae Last Lowe				4. DATE OF DEATH Month June Day 12 Year 19 60			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APR 30, 1914	9. AGE (In years last birthday) 46 yrs.	IF UNDER 1 YEAR Months 46 Days 46 Hours 46 Min.	IF UNDER 24 HRS. Months 46 Days 46 Hours 46 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bank Teller		10b. KIND OF BUSINESS OR INDUSTRY Union Trust Co		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank O. Lowe				14. MOTHER'S MAIDEN NAME Martha K. Lynch			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		INFORMANT Frank O. Lowe			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Leiomys - Pseudomonas of uterus with generalized metastases 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary failure due Lung Metastases							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov , 19 59 to 6/12/1960 that I last saw the deceased alive on 6/12 , 19 60 , and that death occurred at 2:45 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Arch L. Riddick M.D.				DATE SIGNED 6/12/60			
PHYSICIAN'S NAME (Type) Arch L. Riddick				1835 Eye St. N. W. Wash. D. C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/15/60		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumfrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR JUN 15 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Thayer			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1910

CERTIFICATE OF DEATH

1910

58

Robert A. Pugh
Born 10/15/55
Died 10/15/55
Cause of Death
Buried in
Cemetery
Interment
1955

7036

CERTIFICATE OF DEATH

Reg. Dist. No. 07107

1. PLACE OF DEATH o. COUNTY Montgomery Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b 20 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2408 Colston Drive				d. STREET ADDRESS 2408 Colston Drive			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) John Julian Lyne				4. DATE OF DEATH Month June Day 16 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 29 1871	
9. AGE (In years last birthday) 89 yrs.		IF UNDER 1 YEAR Months 4 Days 17		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operated Elevator				10b. KIND OF BUSINESS OR INDUSTRY Grain		11. BIRTHPLACE (State or foreign country) Jefferson Co. W. Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME Charles Barton Lyne				14. MOTHER'S MAIDEN NAME Mary Ellen Lemen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT Mrs. Susan H. Lyne				2408 Colston Drive Silver Spring Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 10 min. 40 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1952 , 19____, to date , 19____, that I last saw the deceased alive on 1 June , 19 60 , and that death occurred at 11:15 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7936 Georgetown Rd Bethesda 14 Md. DATE SIGNED 							
ACTUAL SIGNATURE John S. Ball				M.D. 7936 Georgetown Rd Bethesda 14 Md.			
PHYSICIAN'S NAME (Type) 							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 19-60		22c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery		22d. LOCATION (City, town, or county) (State) Shepherdstown W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Edith V. Leaf				ADDRESS Shelburne Williamsport Md.		24a. REC'D BY REGISTRAR DATE JUN 20 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

26

CERTIFICATE OF DEATH

02107

Deceased: John J. Ryan, 3408 Colston Drive, Silver Spring, Md.
Date of Death: Jan. 29, 1971
Age: 69
Sex: Male
Race: White
Cause of Death: Unspecified
Place of Death: Home
Physician: Dr. J. H. Ryan
Burial: St. Mary's Cemetery, Silver Spring, Md.

Signature: [Illegible]
Date: Jan. 29, 1971
Registrar: [Illegible]

7156

CERTIFICATE OF DEATH

07108

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 10 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Suburban Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last William F. Maher				4. DATE OF DEATH Month Day Year June 23 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/ 79	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Ireland		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Maher				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None		INFORMANT Dr. H.A. Locke		Address 3747 Huntington St. N.W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Atherosclerosis DUE TO (c) Coronary Atherosclerosis						INTERVAL BETWEEN ONSET AND DEATH 24 hours 24 hours years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma Sigmoid Colon, Gas Bacillus Septicemia						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 6-11 , 19 60 , to 6-23 , 19 60 , that I last saw the deceased alive on 6-22 , 19 60 , and that death occurred at 5:40 A.M. , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 5401 Western Ave NW Washington DC				DATE SIGNED			
ACTUAL SIGNATURE James E. Nolan				M.D. 5401 Western Ave NW Washington DC			
PHYSICIAN'S NAME (Type) James E. Nolan							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/25/60		22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR JUN 24 '60	
				24b. REGISTRAR'S SIGNATURE Arthur J. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7157

07109

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 1 day			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Great Mills				d. STREET ADDRESS Box 83			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last John Anthony MARRON				4. DATE OF DEATH Month Day Year June 17 1960			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-1-60		9. AGE (In years last birthday) yrs. 1	IF UNDER 1 YEAR Months 17	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John M. MARRON				14. MOTHER'S MAIDEN NAME Maxine JACKSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain abscess - protens 342X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prematurity							INTERVAL BETWEEN ONSET AND DEATH 7 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the deceased) attended the deceased from June 16 1960 to June 17 1960 that (I) we last saw the deceased alive on June 16 1960 , and that death occurred at 4:40 pm from the causes and on the date stated above.							
22a. SIGNATURE G. B. Avery				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D.		22b. DATE SIGNED 6-17-60	
22c. PHYSICIAN'S NAME (Type) G. B. AVERY, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-20-60		23c. NAME OF CEMETERY OR CREMATORY St. Aloysius		23d. LOCATION (City, town, or county) (State) Leonardtwn, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE MATTHEW L. FUNERAL HOME LEONARDTOWN, MD				25a. REC'D BY REGISTRAR JUN 21 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

2051342XV2



MADE IN U.S.A.

7157

MONROE

William (Paul)

U. S. Naval Hospital

John

Demosthenes

Male

John M. Warren

No

None

Medical Records

Medical Records

Medical Records

2-1-50

Medical Records

Anthony

June 17

Box 03

Grand Mills

1 day

Medical Records

CERTIFICATE OF DEATH

03100

10710

EXHIBIT OF DEATH

1152

101

101

Continued of previous with new information

10710

Continued of previous with new information

Continued of previous with new information

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

07111

7159

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 3720 Williams Lane			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Henry Agett MAY				4. DATE OF DEATH Month Day Year June 21 1960			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-25-74	
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Officer				10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Henry C. MAY				14. MOTHER'S MAIDEN NAME (unknown) AGETT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 1899 to 1938				16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBAR PNEUMONIA. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE, CONDITION GIVEN IN PART I (a) Arteriosclerosis Generalized Fracture (R) humerus.				INTERVAL BETWEEN ONSET AND DEATH unknown.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) June 19 1960				(County) (State)			
21. I certify that (X) (this hospital) attended the deceased from June 19 1960 to June 21 1960 that (X) (we) last saw the deceased alive on June 21 1960 , and that death occurred at 6:40AM , from the causes and on the date stated above.							
22a. SIGNATURE F. J. Dawson II. M.D.				22b. DATE SIGNED 6-21-60			
22c. PHYSICIAN'S NAME (Type) F. J. DAWSON II, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-23-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey				25a. REC'D BY REGISTRAR JUN 24 '60		25b. REGISTRAR'S SIGNATURE Charles L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15

U. S. Naval Hospital, Portsmouth, N.H.
June 21, 1950
Mr. J. H. [illegible]
Washington, D.C.
Dear Sir:
Enclosed for you are two copies of a letterhead memorandum dated and captioned as above.
Very truly yours,
[Signature]
[Title]
U. S. Naval Hospital, Portsmouth, N.H.

U. S. Naval Hospital, Portsmouth, N.H.
June 21, 1950
Mr. J. H. [illegible]
Washington, D.C.
Dear Sir:
Enclosed for you are two copies of a letterhead memorandum dated and captioned as above.
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[Signature]
[Title]
U. S. Naval Hospital, Portsmouth, N.H.

U. S. Naval Hospital, Portsmouth, N.H.
June 21, 1950
Mr. J. H. [illegible]
Washington, D.C.
Dear Sir:
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Very truly yours,
[Signature]
[Title]
U. S. Naval Hospital, Portsmouth, N.H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7059

CERTIFICATE OF DEATH

07112

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Mont.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN 1b unknown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 505 Domer Ave. Apt. 203		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARGARET First Middle McDONOUGH Last		4. DATE OF DEATH 6-20 Month Day Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 10, 1868
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Patrick Kelly		14. MOTHER'S MAIDEN NAME Margaret O'Brien	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Mary Katherine Long Address Takoma Park, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO 420-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH INSTANT	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-3 , 19 39 , to 6-20 , 19 60 , that I last saw the deceased alive on 6/19 , 19 60 , and that death occurred at 6A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6480 N. H. Ave DATE SIGNED 6/20/60			
ACTUAL SIGNATURE R. C. Kirchner		PHYSICIAN'S NAME (Type) R. C. KIRCHNER	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 22, 1960	
22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.		22d. LOCATION (City, town, or county) (State) Richmond, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. Washington, D. C.		24a. REC'D BY REGISTRAR JUN 21 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

07118

CERTIFICATE OF DEATH

7052

(M)

1

(S)

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
M
051
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7160
CERTIFICATE OF DEATH

07113

1. PLACE OF DEATH a. COUNTY Montgomery (Rural) MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY Cape May	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital, NNMC		d. STREET ADDRESS 645 Shore Drive	
3. NAME OF DECEASED (Type or print) First Dorothy Middle Elizabeth Last MC MASTER		4. DATE OF DEATH Month June Day 25 Year 1960	
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 19 1913
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Carl MEDER		14. MOTHER'S MAIDEN NAME Florence BATTERSBY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mahlon M. MC MASTER (same as #2 above)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 175.00 DUE TO CARCINOMATOSIS, OVARY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 15 1960 to June 25 1960 that (I) <input checked="" type="checkbox"/> saw the deceased alive on June 25 1960 , and that death occurred at 12:45 pm M, from the causes and on the date stated above.			
22a. SIGNATURE C. R. BOYCE		22b. DATE SIGNED June 25 1960	
22c. PHYSICIAN'S NAME (Type) C. R. BOYCE LCDR MC USN		22d. ADDRESS U. S. Naval Hospital, NNMC, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment 6-25-60		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Sea Side Cemetery		23d. LOCATION (City, town, or county) (State) Marmora; by New Jersey	
24. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREYS		25a. REC'D BY REGISTRAR JUN 28 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Hume			

(M)

7180

ESTIMATE OF COST

07112

Item No.

(Total)

Item Description

10.000

10.000

U. S. Naval Hospital, Washington, D. C.

Item No.

Item Description

10.000

10.000

U. S. Naval Hospital, Washington, D. C.

U. S. Naval Hospital, Washington, D. C.

U. S. Naval Hospital, Washington, D. C.

U. S. Naval Hospital, Washington, D. C.

June 2, 1960

June 2, 1960

June 2, 1960

U. S. Naval Hospital, Washington, D. C.

U. S. Naval Hospital, Washington, D. C.

U. S. Naval Hospital, Washington, D. C.

U. S. Naval Hospital, Washington, D. C.

U. S. Naval Hospital, Washington, D. C.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 1 and 2 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

7161
MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07114

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>monty</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>23 yrs</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>48 Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4306 Montgomery Ave</u>			d. STREET ADDRESS <u>4306 Montgomery Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>Midday</u> Middle Last			4. DATE OF DEATH <u>June 13 1960</u> Month Day Year		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-20-1901</u>	9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Int. decorator</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
13. FATHER'S NAME <u>UNKNOWN</u>			14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, go, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-32-0702</u>		17. INFORMANT <u>Ellen Midday (wife)</u> Address <u>Stem 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>6-13-60</u>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSCHE</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/15/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>JUN 15 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kline</u>

MEDICAL CERTIFICATION

847

THE STATE
OF NEW YORK

1911

0.118

Robert A. Phipps, Esq.,
at New York, New York,
July 15, 1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

item 1 Film 6264 6-13-60 et

CERTIFICATE OF DEATH

07115

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>28 Silver Springs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Private home</u>		d. STREET ADDRESS <u>1946 Seminary Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>NELLIE WARD MILES</u>		4. DATE OF DEATH Month Day Year <u>June 1 1960</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 9, 1886</u>
9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>music teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Ira Wilson Poff</u>		14. MOTHER'S MAIDEN NAME <u>Callie Huff</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>James P. Miles Sr. 1946 Seminary Rd Silver Springs Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive pulmonary embolus</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial infarction, "recent"</u> DUE TO (c) <u>Arteriosclerotic cardiovascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>2 1/2 months</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>① Malnutrition ② Hypothyroidism</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0.11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>December, 1959</u> to <u>June 1, 1960</u> , that I last saw the deceased alive on <u>May 31, 1960</u> , and that death occurred at <u>8:10 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1834 I Street, N.W., Washington, D.C.</u> DATE SIGNED <u>June 1, 1960</u>			
ACTUAL SIGNATURE <u>George C. Buchanan</u>		M.D. <u>1834 I Street, N.W., Washington, D.C.</u>	
PHYSICIAN'S NAME (Type) <u>George C. Buchanan</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>June 3, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Bluefield, West Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ives Funeral Home, Inc.</u>		ADDRESS <u>Arlington, Va.</u>	
24a. REC'D BY REGISTRAR <u>JUN 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. [unclear]</u>	

7162

CERTIFICATE OF DEATH

07116

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>22 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LeDeau Nursing Home</u>				e. STREET ADDRESS <u>110211 Montgomery Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Albert Elias Miller</u>				4. DATE OF DEATH Month <u>June</u> Day <u>8</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 12, 1876</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>		11. BIRTHPLACE (State or foreign country) <u>Iowa</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Chauncey D. Miller</u>				14. MOTHER'S MAIDEN NAME <u>Marcia Butler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		(If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT <u>Miss Helen Miller - 10211 Montgomery Ave Kensington</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 2</u> , 1960, to <u>June 8</u> , 1960, that I last saw the deceased alive on <u>June 8</u> , 1960, and that death occurred at <u>6 p. M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>1801 Eye St. N.W. Wash D.C.</u> <u>June 8, 1960</u>							
ACTUAL SIGNATURE <u>M. H. Stolar</u>				M.D. <u>1801 Eye St. N.W. Wash D.C.</u>			
PHYSICIAN'S NAME (Type) <u>M. H. Stolar, M.D.</u>				<u>1801 Eye St. N. W. Washington, D. C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/11/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 10 1960</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Stolar</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

42

3182

CERTIFICATE OF DEATH

STATE OF MARYLAND

Attest: I, Robert A. Brantley, Registrar, do hereby certify that the foregoing is a true and correct copy of the original as the same appears from the records of the Department of Health, State of Maryland.

Witness my hand and the seal of said Department at Baltimore, Maryland, this 11th day of April, 1910.

Registrar

Attest: I, John H. Washington, D. C., Secretary, do hereby certify that the foregoing is a true and correct copy of the original as the same appears from the records of the Department of Health, State of Maryland.

Secretary

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7060
CERTIFICATE OF DEATH

07117

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P.R. George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takom Park</u>		c. LENGTH OF STAY IN 1b <u>9 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San & Hospital</u>		d. STREET ADDRESS <u>1215 Valley Drive</u>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Wells</u> Last <u>Miller</u>		4. DATE OF DEATH Month <u>6</u> Day <u>9</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-14-81</u>		
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Gardener</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>James Miller</u>		14. MOTHER'S MAIDEN NAME <u>Mary Montgomery</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>Hospital Records</u>		Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>572.1</u> <u>Pneumonia due to</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> DUE TO <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>5-31</u> 19 <u>60</u> , to <u>6-9</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>6-8</u> 19 <u>60</u> , and that death occurred at <u>3:45</u> AM, from the causes and on the date stated above.					
22a. SIGNATURE <u>W. Moses</u> M.D.		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>William Moses, M.D.</u>		22d. ADDRESS <u>1835 Eye St. N.W. Washington, D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-11-60</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Deak Funeral Home</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>JUN 13 '60</u>			
ADDRESS <u>4812 G. Ave. N.W.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

X

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7163 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07118

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Yaithursting - R-3</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Yaithursting R-3</u>	
c. LENGTH OF STAY IN 1b <u>life</u>		d. STREET ADDRESS <u>Ripple Ford Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Henry Carlton Mobley</u>		4. DATE OF DEATH Month <u>June</u> Day <u>11</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-11-1896</u>
9. AGE (in years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cashier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Seam.</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew J. Mobley</u>		14. MOTHER'S MAIDEN NAME <u>Hamnett A. Selby</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>Hattie Ratcliff - Yaithursting MD R-3</u>	
17. INFORMANT <u>Hattie Ratcliff - Yaithursting MD R-3</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertension</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr.</u> <u>years</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-13-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>		22d. LOCATION (City, town, or country) (State) <u>Yaithursting MD</u>	
23. FUNERAL DIRECTOR <u>Francis C. Frazier</u>		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	
DATE <u>JUN 15 '60</u>			

06

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the medical examiner, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 3 may be retained for your files. File pages 1, 2, and 3 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

7164 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 FilmG265 6-28-60 et

Reg. Dist. No.

07119

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>27 hrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Margaretta</u> Middle <u>Moore</u> Last <u>Moore</u>		4. DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/3/81</u>
9. AGE (In years last birthday) <u>78 yrs.</u>		10. IF UNDER 1 YEAR Months <u>78</u> Days <u>119</u>	11. IF UNDER 24 HRS. Hours <u>78</u> Min. <u>119</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Day Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lewis Sidney</u>		14. MOTHER'S MAIDEN NAME <u>Not known?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Hoof. records</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>16 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u></u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Hour <u>19</u> o. m. <u></u> p. m. <u></u> Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-17-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Rose</u>		22d. LOCATION (City, town, or county) (State) <u>Cloppers, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Knepper</u>		ADDRESS <u>Rockville</u>	
24. REC'D BY REGISTRAR <u>Arthur S. Knepper</u>		DATE <u>6-13-60</u>	
25. REGISTRAR'S SIGNATURE <u>Arthur S. Knepper</u>		DATE <u>6-13-60</u>	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1043. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7165

07120

1. PLACE OF DEATH e. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Montg.			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Seneca				c. LENGTH OF STAY IN 1b 02 Damascus			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Potomac River				d. STREET ADDRESS 27613 Ridge Road			
3. NAME OF DECEASED (Type or print) First Middle Last Donald Monroe Moxley				4. DATE OF DEATH Month Day Year June 6, 1960 19			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/6/1932	9. AGE (In years last birthday) 28 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		
13. FATHER'S NAME Everest M. Moxley			14. MOTHER'S MAIDEN NAME Margaret Bowman				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-28-1287		17. INFORMANT Margaret Welch		Address Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 850x DUE TO drowning Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell or accidentally pushed off of barge anchored in Pot. R.					
20c. TIME OF INJURY Month, Day, Year 8:00 p.m. 6/6/60	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Potomac R.		20f. (City or town) Seneca	(County) Montg.	(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Breschart			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6/6/60		
EXAMINER'S NAME (Type) Frank J. Breschart			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
			Address (Street, city, town, or county)				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 9, 1960	22c. NAME OF CEMETERY OR CREMATORY Montgomery Meth.		22d. LOCATION (City, town, or country) Clagettville, Md.		(State)	
23. FUNERAL DIRECTOR Clm L. Moxley			ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR JUN 9 '60		
					24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

MEDICAL CERTIFICATION

THE
HALL

(M)

LD

(1)

7162

unpublished

Seneca

Potomac River

Donnell's Landing, Mexico

White

Carroll, Cal

Everett, A. Kelly

Everett, A. Kelly

Alphaxia

Alphaxia

6:00 6/6/60

Patricia M. Jones

Patricia M. Jones

6/6/60

Frank J. Thompson

June 6, 1960

June 6, 1960

CERTIFICATE OF DEATH

07121

MEDICAL CERTIFICATION	1. PLACE OF DEATH a. COUNTY Montgomery	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Florida	b. COUNTY ✓	
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)	c. LENGTH OF STAY IN lb 35 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Petersburg	48X3	
	d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital	d. STREET ADDRESS 920 12th Street, S.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
	3. NAME OF DECEASED (Type or print) William Henry MURRAY	First William	Middle Henry	Last MURRAY	4. DATE OF DEATH Month June
	5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-4-91	9. AGE (In years last birthday) yrs. 69
	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner	10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy	11. BIRTHPLACE (State or foreign country) New York	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
	13. FATHER'S NAME Ira A. MURRAY	14. MOTHER'S MAIDEN NAME Johanna BURKE			
	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. 1912-1942	17. INFORMANT (S) Mrs. Mary H. Lapham, same as #2 above	Address	
	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastases from carcinoma of Liver DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 155.0 (b) PRIMARY Carcinoma of Liver DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH 3 wks.			
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (XXXXXX) attended the deceased from May 5 1960 to June 9 1960 , that (I) (xx) last saw the deceased alive on June 9 1960 , and that death occurred 3:17 PM , from the causes and on the date stated above.			
22a. SIGNATURE R. G. Muth	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 6-9-60		
22c. PHYSICIAN'S NAME (Type) R. G. MUTH, LT, MC, USN	22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment	23b. DATE THEREOF 6-9-60	23c. NAME OF CEMETERY OR CREMATORY Woodbrook Cemetery	23d. LOCATION (City, town, or county) (State) Woburn Mass.
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers & Co., 1400 Chapin St. NW, WashDC	ADDRESS	25a. REC'D BY REGISTRAR DATE JUN 13 '60	25b. REGISTRAR'S SIGNATURE Arthur S. Evans

00121

CENTRAL OF DEATH

1186

3. 10000000

25 days

3000000 (10000)

320 1200 3000000

U. S. Naval Hospital

MEANS

Henry

William

25

1-4-91

10000000

10000

U.S.A.

New York

U. S. Navy

10000000

JOHNS HOPKINS

10000000

(3) Mrs. Mary E. Jackson, born in 1890

10000000

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U. S. Naval Hospital

U. S. Naval Hospital

U. S. Naval Hospital

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7167

CERTIFICATE OF DEATH

07122

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 24 HOURS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRY Middle NICHOLSON Last NEHOUSE		4. DATE OF DEATH Month JUNE Day 16 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-21-1881
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry N. Nehouse		14. MOTHER'S MAIDEN NAME Anna Hager	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213.12.4669	
17. INFORMANT HOSPITAL RECORDS		Address OLNEY, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1777X 1777X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 1777X 1777X DUE TO c) 1777X 1777X DUE TO		INTERVAL BETWEEN ONSET AND DEATH 48 HOURS 8 YRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1955 to June 16 1960 that (I) (we) last saw the deceased alive on June 16 1960 , and that death occurred at 10:00 PM , from the causes and on the date stated above.			
22a. SIGNATURE G. F. Meadors Jr.		22b. DATE SIGNED 6/18/60	
22c. PHYSICIAN'S NAME (Type) G. F. MEADORS JR. M. D.		22d. ADDRESS DAMASCUS, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 19 60	
23c. NAME OF CEMETERY OR CREMATORY Salem Methodist		23d. LOCATION (City, town, or county) (State) Cedar Grove Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber		25a. REC'D BY REGISTRAR JUN 21 '60	
ADDRESS Laytonsville, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

07152

CERTIFICATE OF BIRTH

1915



NAME OF CHILD
DATE OF BIRTH
PLACE OF BIRTH

NAME OF FATHER
NAME OF MOTHER
NAME OF REGISTRAR

SIGNATURE OF REGISTRAR



OFFICE OF THE REGISTRAR

STATE OF NEW YORK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7082

CERTIFICATE OF DEATH

07123

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>D. C.</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>KENSINGTON</i>		c. LENGTH OF STAY IN 1b <i>Since 6/18/60</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>WASHINGTON</i>		d. STREET ADDRESS <i>6615 1st St., N.W.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Kensington Gardens</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>BERTHA</i> Middle <i>ALICE</i> Last <i>NOLSON</i>		4. DATE OF DEATH Month <i>June</i> Day <i>22</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 13, 1886</i>
9. AGE (In years last birthday) <i>73</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Benjamin Bridges</i>		14. MOTHER'S MAIDEN NAME <i>Alice Virginia Palmer</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	
17. INFORMANT <i>Mr. Erich Mosettig, 6615 1st St., N.W.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial infarction</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>coronary occlusion</i> DUE TO (c) <i>coronary arteriosclerosis</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>diabetes mellitus</i> INTERVAL BETWEEN ONSET AND DEATH <i>15 minutes</i> <i>15 minutes</i> <i>5 years</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>July 10, 1958</i> to <i>June 22, 1960</i> , that (I) (we) last saw the deceased alive on <i>June 20, 1960</i> , and that death occurred at <i>10:30 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Seruch T. Kimble</i>		22b. DATE SIGNED <i>22 June, 1960</i>	
22c. PHYSICIAN'S NAME (Type) <i>Seruch T. Kimble</i>		22d. ADDRESS <i>929 Potomac Drive, Silver Spring, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>CREMATION</i>		23b. DATE THEREOF <i>6/23/60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>FT. LINCOLN CREMATORY</i>		23d. LOCATION (City, town, or county) (State) <i>PRINCE GEO. COUNTY, MARYLAND</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond E. Pimpsey, INC.</i>		25a. REC'D BY REGISTRAR <i>JUN 27 '60</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 18 Film 265 6-2860									
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
7168									
07124									
1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COLESVILLE					c. LENGTH OF STAY IN 1b 10 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 COLESVILLE		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 812 MIDLAND ROAD					d. STREET ADDRESS 1 812 MIDLAND ROAD			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARGUERITE Middle RUTH Last NOLAN					4. DATE OF DEATH Month JUNE Day 17 Year 1960				
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 12, 1915		9. AGE (In years last birthday) 45 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME EDWARD SCOTT					14. MOTHER'S MAIDEN NAME MABEL REED				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO					16. SOCIAL SECURITY NO. 578-12-2497		17. INFORMANT Address Mr. Thomas F. Nolan, Jr., 812 Midland Road Colesville, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) carcinoma of breast DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 170x DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 14 months									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (the hospital) attended the deceased from Dec. 1959 to June 17, 1960 , that (I) was last saw the deceased alive on June 15, 1960 , and that death occurred at 7 A.M. from the causes and on the date stated above.									
22a. SIGNATURE G. Lennard Gold					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED June 17, 1960		
22c. PHYSICIAN'S NAME (Type) G. LENNARD GOLD					22d. ADDRESS 8641 Colesville Road, Silver Spr., Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/20/60		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY			23d. LOCATION (City, town, or county) (State) PRINCE GEO. COUNTY, MARYLAND		
24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Jaska					ADDRESS SILVER SPRING, MD.		25a. REC'D BY REGISTRAR DATE JUN 21 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Hines

1108

CERTIFICATE OF DEATH

14

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07125
Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b Since May 1959 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Althea-Woodland Nursing Home		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING, d. STREET ADDRESS Street address unknown e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle ALFRED Last OAKLEY SR.		4. DATE OF DEATH Month JUNE Day 23 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 12/6/83
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER, RETIRED		10b. KIND OF BUSINESS OR INDUSTRY PA. RAILROAD	
11. BIRTHPLACE (State or foreign country) MAGNOLIA, HARFORD COUNTY, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS B. OAKLEY		14. MOTHER'S MAIDEN NAME LAURA JANE GROSS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 717-07-8527	
17. INFORMANT Address MRS. LOUISE B. MATEER, 735 Sligo Ave. Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis - generalized DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH sudden years
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		DATE SIGNED 6/23/60	
EXAMINER'S NAME (Type) FRANK J. BROSCHART		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 6/27/60	22c. NAME OF CEMETERY OR CREMATORY COKEBURY CEMETERY	22d. LOCATION (City, town, or county) (State) ABBINGDON, MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE Wagner E. Pumphrey, Inc. ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR JUN 29 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraw

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

RECEIVED
JAN 10 1918

MASSACHUSETTS DEPARTMENT OF HEALTH - BATHING, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF EXAMINER: [illegible]
DATE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7169

CERTIFICATE OF DEATH

07126

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Massachusetts</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reading</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>		d. STREET ADDRESS <u>56 Wakefield Street</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Teresa Ann O'Brien</u>		4. DATE OF DEATH Month Day Year <u>June 15 19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 6, 1956</u>
9. AGE (In years last birthday) yrs. <u>3</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>3</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None (Child)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Maurice J. O'Brien</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Stapleton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT The Medical Record Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cystic Fibrosis</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 Weeks</u> <u>Life</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 18</u> <u>19 60</u> , to <u>June 15</u> <u>19 60</u> , that (I) (we) last saw the deceased alive on <u>June 15</u> <u>19 60</u> , and that death occurred at <u>5:45 P.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Martin J. Wohl</u> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <u>6-15-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>MARTIN J. WOHL, M.D.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>June 18</u>		23b. DATE THEREOF <u>June 18</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Agnes</u>		23d. LOCATION (City, town, or county) (State) <u>Albany, New York</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kraus</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		25c. DATE <u>JUN 20 60</u>	

7189

CERTIFICATE OF DEATH

07189

Blank certificate form with faint horizontal lines and a large, illegible signature in the center.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

07127

1. PLACE OF DEATH a. COUNTY Montgomery 7089 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b 09	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 106 Charles Street		d. STREET ADDRESS 106 Charles Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last HARRIET E. ORRISON		4. DATE OF DEATH Month Day Year June 24, 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 22, 1882
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME George C. Royston		14. MOTHER'S MAIDEN NAME Secy Lawler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 578-30-9047	
17. INFORMANT George L. Orrison-Item# 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RENAL FAILURE DUE TO 181.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HEPATIC FAILURE DUE TO 6 MONTHS (c) CARCINOMA, URINARY BLADDER 5 YEARS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE INTERVAL BETWEEN ONSET AND DEATH 4 MONTHS 6 MONTHS 5 YEARS			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JULY 22, 1953 , to JUNE 24, 1960 , that I last saw the deceased alive on JUNE 22, 1960 , and that death occurred at 1:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Gordon S. Rosenberger		ADDRESS (Street, city or town, state) DATE SIGNED 310 W. Montgomery Ave. June 24, 1960	
PHYSICIAN'S NAME (Type) Gordon S. Rosenberger		Rockville, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/27/60	
22c. NAME OF CEMETERY OR CREMATORY Parklawn		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler		ADDRESS 1331 E. Montgomery Ave. Rockville, Maryland	
24a. REC'D BY REGISTRAR JUN 27 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

09

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7083
CERTIFICATE OF DEATH

07128

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENNINGTON</u>		c. LENGTH OF STAY IN <u>1 week</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KENNINGTON GARDEN SAN</u>		d. STREET ADDRESS <u>5924-9th N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>SAMUEL</u> Middle <u>S.</u> Last <u>PAPER</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>25</u> Year <u>1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-15-1892</u>
9. AGE (In years lost birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ROLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>LAURENCE PAPER</u>		14. MOTHER'S MAIDEN NAME <u>MOLLIE MINTZ</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>RACHAEL PAPER</u>		Address <u>5924-9th NW</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of The Right Lung with metastases</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>163.1</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6-8 mos (?)</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of bladder; Pulmonary embolism</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <u>this hospital</u> attended the deceased from <u>1955</u> to <u>June 25, 1960</u> , that (I) <u>we</u> lost saw the deceased alive on <u>6-25</u> 1960, and that death occurred at <u>7:45</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Morris Perry</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>6-25-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Morris Perry</u>		22d. ADDRESS <u>11602 Georgia Ave, Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/26/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>G.W. Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Hyattsville - Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Hm</u>		ADDRESS <u>4217 9th St NW</u>	
25a. REC'D BY REGISTRAR <u>JUN 28 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Carleton S. Howard</u>	

11752

CENTRAL O. B. B. B.

11752

11752

11752

Handwritten notes and signatures, including "J. B. B. B." and "J. B. B. B.".

7039

CERTIFICATE OF DEATH

07129

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LEDEAU GARDENS SANITORIUM				d. STREET ADDRESS 3307 QUESADA STREET N.W.			
3. NAME OF DECEASED (Type or print) First ELISE D. Middle PARDEE Last PARDEE				4. DATE OF DEATH Month JUNE Day 4 Year 19 60			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 23-79	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months 4 Days 19 Hours 60	IF UNDER 24 HRS. Months 4 Days 19 Hours 60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) LOUISIANA	
13. FATHER'S NAME GASTON DOUSSAN				14. MOTHER'S MAIDEN NAME OLIVA DERBES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 220-000-0000			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Failure DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-sclerotic Heart Disease DUE TO (c) 12 yrs				INTERVAL BETWEEN ONSET AND DEATH 48 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congestive Coronary Lesions & Uremia				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan , 1949, to June , 1960 that I last saw the deceased alive on June 4 , 1960, and that death occurred at 10:30 PM , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) WASHINGTON CLINIC, WASH. D.C.			
ACTUAL SIGNATURE Robert G. Taylor				M.D. WASHINGTON CLINIC, WASH. D.C.			
PHYSICIAN'S NAME (Type) ROBERT G. TAYLOR				II			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 6-7-60		22c. NAME OF CEMETERY OR CREMATORY St. Louis #3 Cemetery New Orleans, Louisiana.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Francis J. Hallin				24a. REC'D BY REGISTRAR Arthur S. Thoms		24b. REGISTRAR'S SIGNATURE Arthur S. Thoms	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0713

CERTIFICATE OF DEATH

7039



WASHINGTON

SILVER SPRING

1900 MARYLAND

MARYLAND

1900

1900

INDIANA

INDIANA

OLIVE TENNESSEE

OLIVE TENNESSEE

OLIVE TENNESSEE

OLIVE TENNESSEE

OLIVE TENNESSEE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7170

CERTIFICATE OF DEATH

07130

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Peru</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lima</u> <u>15X-1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>		d. STREET ADDRESS <u>190 Daniel Carrion</u>	
3. NAME OF DECEASED (Type or print) First <u>Luis</u> Middle <u>Alfonso</u> Last <u>Paz</u>		4. DATE OF DEATH Month <u>June</u> Day <u>18</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 14, 1954</u>
9. AGE (In years lost birthday) <u>5</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Peru</u>		12. CITIZEN OF WHAT COUNTRY? <u>Peru</u> ✓	
13. FATHER'S NAME <u>Jose Paz</u>		14. MOTHER'S MAIDEN NAME <u>Pilar Zapata</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastrointestinal hemorrhage</u> 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) <u>Moniliiasis of esophagus and large intestine</u> DUE TO (c) <u>Acute leukemia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u> <u>10 days</u> <u>10 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe electrolyte imbalance</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 18</u> <u>1960</u> , to <u>June 18</u> <u>1960</u> , that (I) (we) last saw the deceased alive on <u>June 18</u> <u>1960</u> , and that death occurred at <u>12:45 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Paul J. Schwab</u>		22b. DATE SIGNED <u>6/19/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>PAUL J. SCHWAB, M.D.</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>June 25th, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>NATIONAL CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>LIMA, PERU</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co 1400 Chapin St N.W.</u> <u>Wash, D.C.</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 21 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>			

CERTIFICATE OF DEATH

7130

07130

THE STATE OF TEXAS, COUNTY OF DALLAS, I, the undersigned, a duly qualified and licensed physician, do hereby certify that on the 12th day of June, 1910, at the City of Dallas, Texas, I attended the last illness of one [Name], who died at the residence of [Name], and that the cause of death was [Cause of Death], and that the death was not due to any contagious or infectious disease, and that the deceased was not a victim of any criminal offense, and that the death was not due to any other cause than that stated above.

Witness my hand and the seal of my office this 12th day of June, 1910.

[Signature]

My Commission Expires [Date]

7061

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>47X-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District of Columbia</u> WASHINGTON	
c. LENGTH OF STAY IN 1b <u>3 hours</u>		d. STREET ADDRESS <u>818 Butternut St. N.W.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Florence</u> Middle <u>May</u> Last <u>Perkins</u>		4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-20-84</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>75</u> Days <u>75</u> Hours <u>75</u> Min. <u>75</u>	IF UNDER 24 HRS. Months <u>75</u> Days <u>75</u> Hours <u>75</u> Min. <u>75</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Shettle</u>		14. MOTHER'S MAIDEN NAME <u>Eliza I. McComas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-05-6892A</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Bowel</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>153.9</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>W.S. Hospital Records</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u>Mar</u> Day <u>19</u> Year <u>1960</u> Hour <u>11:45</u> a. m. <u>PM</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Silver Spring</u> (County) <u>Prince Geo.</u> (State) <u>MD.</u>	
21. I certify that I attended the deceased from <u>Mar 19, 1960</u> to <u>June 3, 1960</u> , that I last saw the deceased alive on <u>June 2, 1960</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John N. Andrews</u>		DATE SIGNED <u>June 3, 1960</u>	
PHYSICIAN'S NAME (Type) <u>John N. Andrews</u>		ADDRESS (Street, city or town, state) <u>9601 Colosville Rd Silver Spring Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6/6/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Jaska</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>DATE JUN 9 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kins</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

181

CERTIFICATE OF DEATH

1861



[Faint, mostly illegible text, likely a death certificate form with fields for name, age, date, and cause of death.]

7171 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07132

Items 10, 16 Film G266 7-6-60 et

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Echo Heights				c. LENGTH OF STAY IN 1b 58 Glen Echo Heights			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5401 Wehawken Road				d. STREET ADDRESS 5401 Wehawken Road			
3. NAME OF DECEASED (Type or print) First Noble Middle Fountain Last Peters				4. DATE OF DEATH Month 6 Day 23 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/3/08		9. AGE (In years last birthday) 51 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer Crane Op.		10b. KIND OF BUSINESS OR INDUSTRY Navy Gun Fact.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME George F. Peters				14. MOTHER'S MAIDEN NAME Anna Maude Trevey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 578-03-7146		17. INFORMANT Address Hazel Peters-wife-same 2d			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO 976 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bullet wound through skull DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH sudden
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Self inflicted bullet wound through skull					
20c. TIME OF INJURY Hour 12:30 p. m. 6 Month, Day, Year 23 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Glen Echo Hts Montg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Frank J. Broschart</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		6/23/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/26/60		22c. NAME OF CEMETERY OR CREMATORY Potomac Church Cem.		22d. LOCATION (City, town, or county) (State) Potomac, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE JUN 27 '60	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please see the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

58

NAME Robert A. Gumbert		SEX Male		DATE OF BIRTH 12-20-1910		PLACE OF BIRTH St. Louis, Mo.	
OCCUPATION Police		HEIGHT 5-10		WEIGHT 150		COMPLEXION Fair	
EYES Blue		HAIR Brown		BUILD Medium		TATTOOS None	
MARRIAGE Single		EDUCATION High School		RELIGION Catholic		SERVICE U.S. Army	
PRESENT ADDRESS 1234 Main St., St. Louis, Mo.		HOME PHONE 1234		BUSINESS PHONE 5678		EMPLOYER St. Louis Police Dept.	
DATE OF DEATH 12-25-1910		PLACE OF DEATH St. Louis, Mo.		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
SIGNATURE OF DECEASED Robert A. Gumbert		SIGNATURE OF WITNESS John Doe		SIGNATURE OF PHYSICIAN Dr. J. Smith		SIGNATURE OF CLERK J. Brown	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please have the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4)
ISM 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7084
CERTIFICATE OF DEATH

07133

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington c. LENGTH OF STAY IN 1b 8 Mo. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens Sanitarium		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 511 - C St N.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Eugene L. Phillips		4. DATE OF DEATH Month Day Year June 22 1960	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 29, 1880
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Showman	11. BIRTHPLACE (State or foreign country) D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Ephriam Phillips	
14. MOTHER'S MAIDEN NAME Margaret Higgins		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. no		17. INFORMANT Records.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Heart Failure, Compensated DUE TO (c) Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 3 Hours 3 Mont	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) X		20f. (City or town) (County) (State) Washington D.C.	
21. I certify that (I) (this hospital) attended the deceased from October 29, 1959 to June 22, 1960 , that (I) (we) last saw the deceased alive on June 22, 1960 , and that death occurred at 6:20 p. from the causes and on the date stated above.		22a. SIGNATURE Robert T. Thibadeau M.D. 22b. PHYSICIAN'S NAME (Type) Robert T. Thibadeau, M.D.	
22c. SIGNATURE Lee Funeral Home 22d. ADDRESS Washington, D.C.		22e. REC'D BY REGISTRAR JUN 24 '60 22f. REGISTRAR'S SIGNATURE Arthur L. Thibadeau	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-25-60	
23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln		23d. LOCATION (City, town, or county) (State) Bladensburg, Md	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7172

CERTIFICATE OF DEATH

07134

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 11 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 46 Bethesda		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5407 Roosevelt Street				d. STREET ADDRESS 5407 Roosevelt St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First OTTILIA Middle MARIA Last PHILLIPS				4. DATE OF DEATH Month June 3, Day 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 26, 1866		9. AGE (In years lost birthday) 93 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Buffalo, New York		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John J. Schmitz				14. MOTHER'S MAIDEN NAME Johanna Kirsh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Daughter Mrs. Ruth A. Phillips		Address Same as ITEM # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 450.0 IMMEDIATE CAUSE (a) Myocardial Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio sclerosis generalised DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1953 to June 3, 1960 , that (I) (we) last saw the deceased alive on June 19 60 , and that death occurred at 12 PM , from the causes and on the date stated above.							
22a. SIGNATURE <i>Alfred S. Norton</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 4711 Highland Ave., Bethesda, Maryland		22b. DATE SIGNED 6/3/60	
22c. PHYSICIAN'S NAME (Type) ALFRED S. NORTON							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/6/60		23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		23d. LOCATION (City, town, or county) (State) Fredericksburg, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE JUN 8 '60	
				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Haus</i>			

MEDICAL CERTIFICATION

0

1

48

7173

CERTIFICATE OF DEATH

07135

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery P. 6 ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) University Park, Md. 1664.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban		d. STREET ADDRESS 4304 Claggett Rd. University Park	
3. NAME OF DECEASED (Type or print) Adelaide First C. Pohlen Middle Last		4. DATE OF DEATH June 22, 1960 Month Day Year	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/21/14
9. AGE (In years lost birthday) yrs. 46		IF UNDER 1 YEAR Months Days Hours Min. 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Gift Shop	
11. BIRTHPLACE (State or foreign country) Brownsville, Texas		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James J. Fox		14. MOTHER'S MAIDEN NAME Adelaide Celeya	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —	
INFORMANT		Address	
Mr s. Frances Sarles		4104 Dewmar Ct. Kensington	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure DUE TO 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Staphylococcal Pneumonia DUE TO 6 mos (c) Bronchopulmonary fistula + emphysema 3 wks			INTERVAL BETWEEN ONSET AND DEATH Respiratory failure
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April , 1960, to June 22 , 1960, that I last saw the deceased alive on June 21 , 1960, and that death occurred at 6:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1835 E. St NW - Washington DC DATE SIGNED June 22 1960 ACTUAL SIGNATURE Frank A. Ashburn M.D. PHYSICIAN'S NAME (Type) Washington DC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/25/60	22c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	22d. LOCATION (City, town, or county) (State) Wheaton Md.
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	24a. REC'D BY REGISTRAR DATE JUN 24 '60
		24b. REGISTRAR'S SIGNATURE Arthur S. Kinn	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

522

A large handwritten 'X' mark, likely indicating a correction or a specific point of interest on the page.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07136

7174

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 72 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 5807 Phoenix Drive			
3. NAME OF DECEASED (Type or print) First Donald Middle Lee Last Putnam				4. DATE OF DEATH Month June Day 16 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1925		9. AGE (In years last birthday) 35 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Putnam				14. MOTHER'S MAIDEN NAME Hazel Guild			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myelogenous leukemia DUE TO 204.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 20 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 5, 1960 , to June 16, 1960 , that (I) (we) last saw the deceased alive on June 16, 1960 , and that death occurred at 4:45 AM from the causes and on the date stated above.							
22a. SIGNATURE Emanuel S. Hellman, M.D.				22b. DATE SIGNED 6/16/60			
22c. PHYSICIAN'S NAME (Type) Emanuel S. Hellman, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/20/60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR JUN 17 1960 DATE	
				25b. REGISTRAR'S SIGNATURE Robert A. Pumphrey			

45

(A)

Robert A. Anderson, Secretary, National
At-Large National
and
National

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7175

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07137

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Utah b. COUNTY Salt Lake	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 12 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salt Lake City 81X-3	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 181 Edith Ave.	
3. NAME OF DECEASED (Type or print) Rose Litster Ramussen		4. DATE OF DEATH Month June Day 5 Year 19 60	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/30/83	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min. 76	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Utah	
11. BIRTHPLACE (State or foreign country) Utah		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Robert Litster		14. MOTHER'S MAIDEN NAME Jane Cunning	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Dr. Grant Ramussen (Son)		Address 9801 Broadstreet Bethesda Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary insufficiency DUE TO (c) Coronary insufficiency PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diff. while undergoing sympathectomy under gen. anesthesia			
INTERVAL BETWEEN ONSET AND DEATH Sudden			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank Brochart M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 6-5-60			
EXAMINER'S NAME (Type) Frank Brochart			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-Transit 22b. DATE THEREOF 6/6/60 22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet 22d. LOCATION (City, town, or county) (State) Salt Lake City, Utah			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland 24a. REC'D BY REGISTRAR JUN 8 '60 24b. REGISTRAR'S SIGNATURE Arthur S. Travis			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Monty</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7311 Commander La</u>				d. STREET ADDRESS <u>7311 Commander La</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Hugo</u> Middle <u>Reyer</u> Last <u></u>				4. DATE OF DEATH Month <u>June</u> Day <u>25</u> Year <u>1960</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-2-1892</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst. (gov.) Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Unk</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Adam Reyner</u>				14. MOTHER'S MAIDEN NAME <u>Emma Reich</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give war or dates of service) <u>WW 1</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Martha H. Reyner</u>	
Address <u>Stuen 2</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in chair</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u></u> o. m. <u></u> p. m. <u></u>		Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/29/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>JUN 28 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Carlton S. House</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please excuse this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH HANSTAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.		NAME: Robert A. Campbell SEX: Male DATE OF BIRTH: 12/24/30 PLACE OF BIRTH: Attingham, Attingham, Virginia	
OCCUPATION: None PRESENT ADDRESS: None HOME PHONE: None BUSINESS PHONE: None		DEATH DATE: 12/24/30 DEATH TIME: 11:00 AM DEATH PLACE: Attingham, Attingham, Virginia	
CAUSE OF DEATH: None MANNER OF DEATH: None MEDICAL HISTORY: None PRESENT ILLNESS: None TREATMENT: None POST-MORTEM: None SIGNATURE: None DATE: None		SIGNATURE: None DATE: None TITLE: None OFFICE: None COUNTY: None STATE: None	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

1
7176
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

07139

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poolesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Matthews Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BETTY Middle R. Last RICHARDSON		4. DATE OF DEATH Month JUNE Day 4 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/28/1866
9. AGE (In years last birthday) 93 yrs.		10. IF UNDER 1 YEAR Months 13 Days 8	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Richard Simpson		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Harry E. Richardson-son-same 2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hychostatic pneumonia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1-week 2 months 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 6, 1955 , to 4 June, 1960 that I last saw the deceased alive on 4 June, 1960 , and that death occurred at 8 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Darmanville DATE SIGNED 6/9/60 ACTUAL SIGNATURE John G. Fawcett M.D. P.O. Boyal Md. PHYSICIAN'S NAME (Type) John G. Fawcett			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/6/60	
22c. NAME OF CEMETERY OR CREMATORY St. Mark's Cemetery		22d. LOCATION (City, town, or county) (State) Highland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Md.	
24a. REC'D BY REGISTRAR JUN 8 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

07130

CERTIFICATE OF DEATH

7172

Montgomery

Maryland

Montgomery

Boyle

Boyleville

Box 20

Box 20

4/24/1900

4/24/1900

10

Montgomery

Montgomery

Montgomery

Richard Simpson

John E. Richardson - age 31

John E. Richardson

John E. Richardson

7040

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING				c. LENGTH OF STAY IN 1b 8 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2408 DARROW STREET				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ALLAN Middle ALEXANDER Last ROSS				4. DATE OF DEATH Month JUNE Day 17 Year 1960			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/3/97		9. AGE (In years lost birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Language Instructor		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.		11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME NICHOLAS ROSS				14. MOTHER'S MAIDEN NAME MARIA GABRIAL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 578-54-6791		INFORMANT Address Mrs. Margaret S. Ross, 2408 Darrow St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 3 yrs. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None INTERVAL BETWEEN ONSET AND DEATH 20 min							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August, 1956 , to June, 1960 that I last saw the deceased alive on June 17, 1960 and that death occurred at 6:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8641-Coleman Road Silver Spring, Maryland DATE SIGNED 6/17/60 ACTUAL SIGNATURE Ralph F. Patten M.D. PHYSICIAN'S NAME (Type) RALPH F. PATTEN							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/20/60		22c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE WAGNER E. PUMPHREY, INC. Raymond A. Ziska				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR DATE JUN 21 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1040

4

0

DECEASED

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

ED

DOB

POB

POB

POB

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DECEASED

DECEASED

DECEASED

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07181

RECEIVED
JAN 2 1973
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C.

Director of Columbia

WASHINGTON

1225 River

WASHINGTON

June 24

RECEIVED
JAN 2 1973
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C.

RECEIVED
JAN 2 1973
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C.

Pauline Winery

Dr. William Russell

State

Home

Mrs. Pauline Winery, Home, State, D.C.

James D. Kennedy

JAMES D. KENNEDY

Official - 6-27-66
Congressional Cemetery, Washington, D.C.

Robert A. Kennedy
Home, State, D.C.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7062
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08142

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, MD</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium + Hospital</u>			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lewisdale,</u> <u>1658-2</u> d. STREET ADDRESS <u>2250 Hannon Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Albert Ryon</u>		4. DATE OF DEATH Month Day Year <u>June 24 1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 7, 1904</u>	9. AGE (In years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Medical Doctor</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
13. FATHER'S NAME <u>Albert Ryon</u>			14. MOTHER'S MAIDEN NAME <u>Adelaide Kreps</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, go, or unknown) (If yes, give year or dates of service) <u>Yes U.W.T.</u>		16. SOCIAL SECURITY NO. <u>- - -</u>		17. INFORMANT Address <u>Mrs. Emmabelle Ryon 2250 Hannon Street</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe congestive heart failure</u> 420.1 DUE TO (b) <u>Cardiac hypertrophy with acute cardiac dilatation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>Severe coronary artery atherosclerosis with multiple large healed myocardial infarcts.</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>6-24-60</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>6/27/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>		22d. LOCATION (City, town, or country) (State) <u>Ft. Myer, Va.</u>	
23. FUNERAL DIRECTOR <u>THE S. H. LINES CO. 2901 14th N.W. WASH. D.C.</u>		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

THE STATE
OF NEW YORK
COUNTY OF NEW YORK



58



IN SENATE,
January 10, 1901.

REPORT
OF THE
COMMISSIONER OF THE LAND OFFICE,
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE,
MAY 1, 1899.

ALBANY:
J. B. LIPPINCOTT & CO.,
PRINTERS,
1899.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7178

CERTIFICATE OF DEATH

07143

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 22 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY Goshen (Rural) e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Eugene Franklin SALE		4. DATE OF DEATH Month Day Year June 11 19 60	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 25 1928
9. AGE (In years lost birthday) 32 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Arthur Thomas SALE		14. MOTHER'S MAIDEN NAME Zeta Evelyn SKIDMORE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 1949 - 52	
17. INFORMANT Helene C. SALE (wife)		Address #2 Above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Embolism, cerebral DUE TO (b) Myocardial stenosis, rheumatic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Aortic stenosis, rheumatic		INTERVAL BETWEEN ONSET AND DEATH 3 days 3 yrs + 3 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 20 1960 to June 11 1960 , that (I) (we) last saw the deceased alive on June 11 1960 , and that death occurred at 4:15 AM from the causes and on the date stated above.			
22a. SIGNATURE R. G. Thomas LT MC USN		22b. DATE SIGNED June 14 '60	
22c. PHYSICIAN'S NAME (Type) R. G. Thomas LT MC USN		22d. ADDRESS U.S. Naval Hospital Staff	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 6-11-60		23b. DATE THEREOF 6-11-60	
23c. NAME OF CEMETERY OR CREMATORY Ridgeburg Cemetery		23d. LOCATION (City, town, or county) (State) Orange County, N. J.	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Humphrey		25a. REC'D BY REGISTRAR JUN 14 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		25c. ADDRESS 7557 Wisconsin Ave Bethesda, Md	

(M)

1

CONFIDENTIAL

2-1-58 (Rural)

23 days

Johnson (Rural)

U. S. Naval Hospital

R.D. 2

Engine

Planning

SAIR

June 11

Cause

April 23 1958

U. S. A.

Planning

Missouri

John Smith's EXHIBITS

John Thomas SAIR

Yes - 1958 - 58 - Missouri

Helene C. SAIR (Miss)

At Above

June 11

May 30

June 11

60

R. C. Smith by Mr. SA

U. S. Naval Hospital

2-1-58 - 2-1-58

U. S. Naval Hospital

U. S. Naval Hospital

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7179

CERTIFICATE OF DEATH

Reg. Dist. No.

07144

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Laytonsville</u>		c. LENGTH OF STAY IN 1b <u>1 1/2 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hawkins Creamery Rd.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Laytonsville</u> 01	
3. NAME OF DECEASED (Type or print) <u>Peter</u> First <u>Vincent</u> Middle <u>SCHREINER</u> Last		4. DATE OF DEATH <u>June</u> Month <u>3</u> Day <u>1960</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 21 1891</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer - Merchant</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	
13. BIRTHPLACE (State or foreign country) <u>Iowa</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
15. FATHER'S NAME <u>George Schreiner</u>		16. MOTHER'S MAIDEN NAME <u>Anne Ziemehut</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		18. SOCIAL SECURITY NO. <u>504 36 9803</u>	
19. INFORMANT <u>Mrs Elizabeth Marshall</u> Address <u>Guithersburg Rt 2 Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic failure</u> 190.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Malignant Melanoma</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>1 1/2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March</u> , 19 <u>60</u> , to <u>June 3</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>June 3</u> , 19 <u>60</u> , and that death occurred at <u>8:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard A. Yates M.D.</u>		ADDRESS (Street, city or town, state) <u>Olney Md.</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD A. YATES</u>		DATE SIGNED <u>6/3/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 6, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Rose</u>		22d. LOCATION (City, town, or county) (State) <u>Clonners, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Oliver L. Mohan</u> ADDRESS <u>Damascus, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 8 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07145

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>15 minutes</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San & Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>8221 Flower Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Eudora</u> First <u>Eudora</u> Middle <u>Shields</u> Last <u>Shields</u>		4. DATE OF DEATH <u>6-23-1960</u> Month <u>6</u> Day <u>23</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 15-1891</u> 9. AGE (In years last birthday) <u>69</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. 9.</u>	
13. FATHER'S NAME <u>John S. Shields</u>		14. MOTHER'S MAIDEN NAME <u>Alice Paxton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Washington Sanitarium & Hospital</u>		Address <u>Washington Sanitarium & Hospital</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GENERALIZED PERITONITIS AND SHOCK</u> DUE TO <u>PERFORATION OF COLON AND RECTUM</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>CARCINOMA OF RECTO-SIGMOID COLON</u>		INTERVAL BETWEEN ONSET AND DEATH <u>HOURS</u> <u>HOURS</u> <u>MONTHS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>153.3</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> e.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brosch</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/27/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>SHOOPS CEMETERY</u>		22d. LOCATION (City, town, or country) (State) <u>HARRISBURG, PENNSYLVANIA</u>	
23. FUNERAL DIRECTOR <u>Raymond A. Zucka</u>		24a. REC'D BY REGISTRAR <u>JUN 30 '60</u>	
ADDRESS <u>SILVER SPRING, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

07113

7088

THE STATE
DEPARTMENT
WASHINGTON
D. C.
20540

1

RECEIVED
JAN 10 1960
U. S. DEPARTMENT OF STATE
WASHINGTON, D. C. 20540

7064

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>8 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hospital</u>		d. STREET ADDRESS <u>8359 Colesville Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Thomas</u> Last <u>Short</u>		4. DATE OF DEATH Month <u>June</u> Day <u>4</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-1-85</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Govt Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>F.H.A.</u>	
11. BIRTHPLACE (State or foreign country) <u>Mass.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Short</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Burke</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>W.S. Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.1</u> (c) <u>Coronary arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>sev'l years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/27/50</u> , to <u>6/4/50</u> , that I last saw the deceased alive on <u>6/4/50</u> , and that death occurred at <u>11:12 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Donald Nelson</u> M.D. <u>10620 Georgia Ave Silver Spring, Md.</u>		DATE SIGNED <u>6/1/50</u>	
PHYSICIAN'S NAME (Type) <u>DONALD NELSON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6/7/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>JUN 9 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

25

CERTIFICATE OF DEATH

7180

18

Montgomery

Rev. John

Residence (Home)

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U. S. Naval Hospital

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Kevin

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

07149

7072

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE		c. LENGTH OF STAY IN 1b 3 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4822 MORGAN DRIVE		d. STREET ADDRESS 4822 MORGAN DRIVE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ALFRED Middle MYATT Last SMITH		4. DATE OF DEATH Month 6th Day 2 Year 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 11, 1882
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT		10b. KIND OF BUSINESS OR INDUSTRY STORE	
11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENDERSON FRANK SMITH		14. MOTHER'S MAIDEN NAME MARY P. MYATT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 242-16-2140	
17. INFORMANT MARGARET S. WILLIAMS DAUGHTER		Address 4822 MORGAN DR. CHEVY CHASE, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 540.0 GASTRIC HEMORRHAGE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PEPTIC ULCER, RECURRENT DUE TO (c) ARTERIOSCLEROSIS GENERALIZED		INTERVAL BETWEEN ONSET AND DEATH 8 DAYS 6 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROSIS GENERALIZED		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from OCTOBER 1959 to JUNE 2, 1960 , that I last saw the deceased alive on MAY 31, 1960 , and that death occurred at 7:10 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert h. Coale		ADDRESS (Street, city or town, state) 4630 Montgomery Ave. Bethesda Md.	
DATE SIGNED 6/2/60			
PHYSICIAN'S NAME (Type) ROBERT N. COALE			
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit		22b. DATE THEREOF 6/2/60	
22c. NAME OF CEMETERY OR CREMATORY Oakwood Cemetery		22d. LOCATION (City, town, or county) (State) Raleigh, North Carolina	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR JUN 3 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If only a physician is necessary, please execute and forward to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7181

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07150

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>Rushton</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 19, 1952</u>
9. AGE (In years last birthday) <u>7</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11a. MALE OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (State or foreign country) <u>Charlottesville, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph H. Smith</u>		14. MOTHER'S MAIDEN NAME <u>Constance Williams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Joseph H. Smith (as above) father</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Intracerebral hemorrhages</u> 8/2X DUE TO <u>Cerebral Contusions and Lacerations</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>Basal Skull Fracture</u> (c) <u>Sudden</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Sudden</u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pedestrian, reported to have run on st. in front of approaching car.</u>	
20c. TIME OF INJURY Hour <u>3:30</u> p.m. Month, Day, Year <u>6-13 1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		20f. (City or town) <u>Bethesda</u> (County) <u>Monty</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BROSCANT</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/16/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 16 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hays</u>	

DATE SIGNED

6-14-60

44

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7182 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07151

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>13 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>59 Bethesda</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6130 Bradley Blvd</u>				d. STREET ADDRESS <u>6130 Bradley Blvd</u>			
3. NAME OF DECEASED (Type or print) <u>Yowans</u> First <u>Smith</u> Last				4. DATE OF DEATH <u>June 9 1960</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-25-05</u>	9. AGE (in years last birthday) <u>55</u> yrs.	IF UNDER 9 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>N. J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wiman H. Smith</u>				14. MOTHER'S M maiden NAME <u>Sarah Louise Gowans</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW 2 118-07-7062</u>		17. INFORMANT <u>Police record.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Coronary Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>u</u> <u>unknown</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>6-10-60</u>			
Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/17/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem</u>		22d. LOCATION (City, town, or country) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>				24a. REC'D BY REGISTRAR <u>DATE JUN 17 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

MEDICAL CERTIFICATION

10-10-60
10-10-60

(M)

59

1

Yes

W 2

110-07-7002

William H. Smith

Seta/ Louise Gowan

Serial

6/7/60

Arlington National Cemetery, Arlington, Virginia

Robert A. Rutherford

Bethesda, Maryland

June 17, 60

Chesapeake

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07153

7041 Items 11, 12, 13 Film 6265 6-24-60 et

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Maryland Chevy Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LeDeau Gardens Nursing Home</u>		d. STREET ADDRESS <u>19200 Jones Mills Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Stafford</u> Last <u>Stafford</u>		4. DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Mary Petenia</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Oliver E. Stafford</u>		Address <u>9200 Jones Mills Rd. CH.CH.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis, Progressive</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 19 59</u> to <u>June 13 19 60</u> that (I) (we) last saw the deceased alive on <u>Jun 7 19 60</u> and that death occurred at <u>8:05 pm</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert T. Thibadeau</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22b. PHYSICIAN'S NAME (Type) <u>Robert T. Thibadeau, M.D.</u>		22c. ADDRESS <u>10609 Concord St., Kensington, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-16-60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Forest Glenn Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas R. Newton</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 21 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur B. Kinn</u>			

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7183

CERTIFICATE OF DEATH

Reg. Dist. No.

07154

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>8 hrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		d. STREET ADDRESS <i>306 Grabb Avenue</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Baby Boy Steinling</i>		4. DATE OF DEATH Month Day Year <i>June 4 1960</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 4, 1960</i>
9. AGE (In years last birthday) <i>16 yrs</i>		IF UNDER 1 YEAR Months Days <i>16</i>	IF UNDER 24 HRS. Min. <i>16</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>David Steinling</i>	
14. MOTHER'S MAIDEN NAME <i>Ruth</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO.		INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <i>776X</i> IMMEDIATE CAUSE (a) <i>Prematurity</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>16 hours</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>4 June, 1960</i> to <i>4 June, 1960</i> , that I last saw the deceased alive on <i>4 June, 1960</i> , and that death occurred at <i>4:20 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W. H. Mitchell</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>M.D. 8218 Wisconsin Ave Bethesda Md 4 June 1960</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>cremation</i>	22b. DATE THEREOF <i>6-4-60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Suburban hospital</i>	22d. LOCATION (City, town, or county) (State) <i>8600 Old Georgetown Rd. Bethesda, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Suburban hospital</i>		24a. REC'D BY REGISTRAR <i>6-6-60</i>	
ADDRESS <i>Bethesda, Maryland</i>		24b. REGISTRAR'S SIGNATURE <i>Bethesda, Md.</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JUN 8 '60

Arthur S. Haines

90

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18														
7-15-60														
See: Birth Cert. et														
7065														
CERTIFICATE OF DEATH														
Reg. Dist. No. 07155														
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u> ✓									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> <u>Rural Route #1</u>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium and Hospital</u>					d. STREET ADDRESS <u>13X-2</u>									
3. NAME OF DECEASED (Type or print) First Middle Last <u>Strickland</u>					4. DATE OF DEATH Month Day Year <u>6</u> <u>20</u> <u>1960</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/20/60</u>		9. AGE (In years last birthday) <u>—</u> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>		13. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <u>—</u> <u>—</u> <u>1</u> <u>40</u>						
13. FATHER'S NAME <u>Hester Strickland</u>					14. MOTHER'S MAIDEN NAME <u>Violet Elsie Howington</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>					16. SOCIAL SECURITY NO. <u>—</u>					17. INFORMANT Address <u>Hospital Records</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anoxia</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prematurity</u> DUE TO (c) <u>—</u>										INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>				
20f. (City or town) (County) (State) <u>—</u>					21. I certify that I attended the deceased from <u>2:25am 6-20 19 60</u> , to <u>4:15am 6-20 19 60</u> , that I last saw the deceased alive on <u>June 20</u> , 19 <u>60</u> , and that death occurred at <u>4:15am</u> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Charles R. Hughes</u> M.D.					ADDRESS (Street, city or town, state) <u>8226 Fenton Street, Silver Spring, Md.</u>					DATE SIGNED <u>—</u>				
PHYSICIAN'S NAME (Type) <u>Charles R. Hughes, M.D., 8226 Fenton Street, Silver Spring, Md.</u>					22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>					22b. DATE THEREOF <u>6-21-60</u>				
22c. NAME OF CEMETERY OR CREMATORY <u>Washington San. & Hosp.</u>					22d. LOCATION (City, town, or county) (State) <u>Takoma Park Maryland</u>									
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Robert Hare, M.D., Wash. San. & Hosp.</u>					24a. REC'D BY REGISTRAR DATE <u>JUN 28 '60</u>					24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>				

2605

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07156

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 2 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hospital		d. STREET ADDRESS 5911 Harwick Rd.	
3. NAME OF DECEASED (Type or print) Ralph McMath Tucker Jr.		4. DATE OF DEATH June 17 1960	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 30, 1950
9. AGE (In years last birthday) 9 yrs.		10. UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Ralph McMath Tucker		14. MOTHER'S MAIDEN NAME XXXXXXXX Joy Hebert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Father		Address Ralph Tucker 5911 Harwick Rd. Bethesda, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Herniation of Brain Stem 813X DUE TO (b) Cerebral Edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) Cerebral Concussion INTERVAL BETWEEN ONSET AND DEATH Sudden Sudden 2 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Right pneumothorax and intrapulmonary hemorrhage		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Reflected car across street in front of approaching car	
20c. TIME OF INJURY Hour 5-00 a.m. 6-17 19 60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) street		20f. (City or town) Bethesda (County) Monty (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Brosch		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) FRANK J. Brosch		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED June 18 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/21/60	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR DATE JUN 21 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

PLACE OF DEATH HOME		SEX MALE	
DATE OF DEATH JAN 10 1900		TIME OF DEATH 10:00 AM	
PLACE OF BIRTH NEW YORK		AGE 35	
OCCUPATION CLERK		CAUSE OF DEATH HEART DISEASE	
MANNER OF DEATH NATURAL		MEDICAL HISTORY NONE	
NAME OF DECEASED JOHN J. BROWN		NAME OF MEDICAL EXAMINER DR. J. H. BROWN	
ADDRESS OF DECEASED 123 MAIN ST. BOSTON		ADDRESS OF MEDICAL EXAMINER 456 STATE ST. BOSTON	
SIGNATURE OF DECEASED (None)		SIGNATURE OF MEDICAL EXAMINER (None)	
SIGNATURE OF NEAREST RELATIVE (None)		SIGNATURE OF WITNESSES (None)	
SIGNATURE OF MEDICAL EXAMINER (None)		SIGNATURE OF MEDICAL EXAMINER (None)	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7075

CERTIFICATE OF DEATH

Reg. Dist. No. 07157

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 07 Gaithersburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 330 E. Diamond Ave.				d. STREET ADDRESS 330 E. Diamond Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HENRY First (NMI) Middle WALTON Last				4. DATE OF DEATH June 16, Month 1960 Day Year			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 2, 1879	
9. AGE (In years lost birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Plumber	
11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Walton			
14. MOTHER'S MAIDEN NAME Jane Irwin		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None	
17. INFORMANT Joseph Walton-Item # 2		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO 420-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE 30 years DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prostatism with CHRONIC RENAL FAILURE						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from AUGUST 19, 1958 , to JUNE 16, 1960 , that I last saw the deceased alive on JUNE 15, 1960 , and that death occurred at 2 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Gordon S. Rosenberger M.D.				ADDRESS (Street, city or town, state) 310 W. MONTGOMERY AVE DATE SIGNED 16 June 1960			
PHYSICIAN'S NAME (Type) Gordon S. Rosenberger				ROCKVILLE, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 6/18/60		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		22d. LOCATION (City, town, or county) (State) Prince George Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler ADDRESS 1331 E. Montgomery Ave. Rockville, Md.				24a. REC'D BY REGISTRAR JUN 20 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hirsch	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07158

7042

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>MD</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>20 yrs.</u>		d. STREET ADDRESS <u>1811 Myrtle Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1811 Myrtle Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Marian Cecilian Washington</u>		4. DATE OF DEATH <u>June 24 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-12-1910</u>
9. AGE (In years last birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DC.</u>	
11. BIRTHPLACE (State or foreign country) <u>DC.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Maurice McCuliffe</u>		14. MOTHER'S MAIDEN NAME <u>HAMMER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>Margaret McCuliffe</u>	
17. INFORMANT <u>Margaret McCuliffe</u>		Address <u>1304 Uranium St N.W.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>G-24-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-28-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR <u>F. J. Collins</u>		ADDRESS <u>WASH. D.C.</u>	
24a. REC'D BY REGISTRAR <u>Francis J. Collins</u>		24b. REGISTRAR'S SIGNATURE <u>Francis J. Collins</u>	
DATE <u>JUN 27 '60</u>			

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1

03:28

1025

RECEIVED
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE
TIME

[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "RECEIVED" and "MEDICAL EXAMINER'S CERTIFICATE OF DEATH" are visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7076

CERTIFICATE OF DEATH

Reg. Dist. No. 07159

1. PLACE OF DEATH a. COUNTY Montg MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montg,	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg. Md.		c. LENGTH OF STAY IN 1b 40Yrs	
d. NAME OF HOSPITAL (If nat in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS Summit Ave	
3. NAME OF DECEASED (Type or print) First Lillian Middle Nevada Last Wells		4. DATE OF DEATH Month June Day 16 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 26-1879
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 10 Days 18	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Home Work	
11. BIRTHPLACE (State or foreign country) Spencer Va,		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Berry D. Grogan		14. MOTHER'S MAIDEN NAME Virginia Dare	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Robert L. Wells. Rockville. Md.	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Vascular Accident DUE TO (c) Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH sudden 1 wk years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 2 , 19 60 , to June 16 , 19 60 , that I last saw the deceased alive on June 15 , 19 60 , and that death occurred at 1:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Frank J. Broschew M.D.			
PHYSICIAN'S NAME (Type) FRANK J. Broschew			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-16-60	22c. NAME OF CEMETERY OR CREMATORY ParkLawn	22d. LOCATION (City, town, or county) (State) Rockville. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner. Gaithersburg. Md.		24a. REC'D BY REGISTRAR DATE JUN 20 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

(M)

(1)

7032

COPIES OF REPORT

0150

NAME

WELLS, JAMES W.

STREET

CITY

STATE

DATE

JULY 22-1946

WELLS, JAMES W.

WELLS, JAMES W.

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WELLS, JAMES W.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7185

07160

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY COUNTY GENERAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOYDS d. STREET ADDRESS R-1 Box 265 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last BEULAH MAY WHITE		4. DATE OF DEATH Month Day Year JUNE 6 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 1, 1908
9. AGE (In years lost birthday) 51 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ARTHUR MILLER		14. MOTHER'S MAIDEN NAME MISSOURI EVERETT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT HOSPITAL RECORDS		Address OLNEY, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Coma 092X DUE TO Acute viral hepatitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 3 months DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bilateral Bronchopneumonia			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 2 19 60 , to June 6 19 60 , that (I) last saw the deceased alive on June 6 19 60 , and that death occurred at 10:28 P.M. from the causes and on the date stated above.			
22a. SIGNATURE G. F. Meadors Jr. M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) G. F. MEADORS, JR. M. D.		22d. ADDRESS DAMASCUS, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-10-60	
23c. NAME OF CEMETERY OR CREMATORY Bayard W. de		23d. LOCATION (City, town, or county) (State) Bayard W. de	
24. FUNERAL DIRECTOR'S SIGNATURE Deal Funeral Home		25a. REC'D BY REGISTRAR 9 1960	
25b. REGISTRAR'S SIGNATURE C. L. S. King		25c. ADDRESS 4812 Ga. Ave. N.W. D.C.	

1951

CERTIFICATE OF DEATH

1951



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1

STATE OF NEW YORK

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

BOYER

DEATH

1951 MAY 20

HONOLULU CITY AND COUNTY, TERRITORY OF HAWAII

WHITE

MALE

WHITE

HAWAIIAN

MALE

1951 MAY 20

DEATH

STATE OF NEW YORK

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

7066

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07161

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 32 SILVER SPRING	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SAN. & HOSPITAL				d. STREET ADDRESS 1 2302 BLUE RIDGE AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROBERT Middle YOUNG Last WHITE				4. DATE OF DEATH Month JUNE Day 9 Year 19 60			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/1/13		9. AGE (In years lost birthday) 46 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus driver		10b. KIND OF BUSINESS OR INDUSTRY D.C. Transit Co.		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN WHITE				14. MOTHER'S MAIDEN NAME MARY YOUNG			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW #2		17. INFORMANT Address Mrs. M. Lucille White, 2302 Blue Ridge Ave. Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Increased intracranial pressure DUE TO 199.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Brain tumor DUE TO (c) 1 year							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiac disease							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 15, 1960 to June 9, 1960 , that (I) (we) last saw the deceased alive on June 6, 1960 , and that death occurred at 8 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Harvey H. Ammerman M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED June 9-1960	
22c. PHYSICIAN'S NAME (Type) Harvey H. Ammerman				22d. ADDRESS 2025 Eye St. N.W. WASH. D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/13/60		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY		23d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Pumphrey, Inc.				25a. REC'D BY REGISTRAR DATE JUN 14 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

MEDICAL CERTIFICATION

32

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7086

CERTIFICATE OF DEATH

Reg. Dist. No.

07162

1. PLACE OF DEATH o. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Kensington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5002 Bangor Drive				d. STREET ADDRESS 5002 Bangor Drive			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Eugene Middle G Last Wiedman				4. DATE OF DEATH Month June Day 4 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/26/1890		9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months 4 Days 8	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Wiedman				14. MOTHER'S MAIDEN NAME Caroline Pficemyer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 147-26-1306		17. INFORMANT William Wiedman-son-same 2d Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anas rca 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic carcinoma of the pancreas DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 2 weeks 12 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from July 27 , 19 59 , to 3 June , 19 60 , that I last saw the deceased alive on 3 June , 19 60 , and that death occurred at 7:40 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10511 Summit Ave DATE SIGNED 6/4/60 ACTUAL SIGNATURE Horace W. Bernton, MD. PHYSICIAN'S NAME (Type) Horace W. Bernton, M.D. Kensington, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/8/60		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE JUN 8 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07163

7099

Items 6,13,14,15 FilmG264 6-13-60 et

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Hayes Middle Williams Last		4. DATE OF DEATH Month June Day 3 Year 1960	
5. SEX male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/10/1925
9. AGE (in years last birthday) 34 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grave digger		11b. KIND OF BUSINESS OR INDUSTRY	
12. BIRTHPLACE (State or foreign country) Maryland		13. CITIZEN OF WHAT COUNTRY? USA	
14. FATHER'S NAME Augustus Williams		15. MOTHER'S MAIDEN NAME Lulu Williams (Maiden name)	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		17. SOCIAL SECURITY NO. Police Record	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Severance of left jugular vein DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Shot gun and stab wound in left chest			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Unknown at this time	
20c. TIME OF INJURY Month, Day, Year 6/3/60 19 Hour a. m. 2:00		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home	
20e. (City or town) Rockville (County) Montg. (State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		DATE SIGNED 6/4/60	
EXAMINER'S NAME (Type) Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-7-60	
22c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant		22d. LOCATION (City, town, or county) (State) Norbeck, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR JUN 8 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
DEATH CERTIFICATE

X

DEATH FORM

THIS FORM IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON QUALIFIED TO CERTIFY TO THE CAUSE OF DEATH. IT IS TO BE FILED IN THE DEATH CERTIFICATE FILE OF THE COUNTY WHERE THE DEATH OCCURRED.

100-100

MAINE STATE DEPARTMENT OF HEALTH - BATHING 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1000

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		RELIGION		POLITICAL PARTY	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF MEDICAL EXAMINER		SIGNATURE OF JURY		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF NOTARY	
DATE		TIME		PLACE		HOUR		MINUTE		SECOND	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07164

7043

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 7/59

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Monty</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>30 Silver Spring</u>	
c. LENGTH OF STAY IN TB <u>4 1/2 yrs</u>		d. STREET ADDRESS <u>305 Lanark Way</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary Amelia Williams</u>		4. DATE OF DEATH <u>June 9 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-1-1906</u>
9. AGE (in years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>N.J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Earley</u>		14. MOTHER'S MAIDEN NAME <u>Mary Sullivan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>578-30-2305</u>	
17. INFORMANT <u>David Williams</u>		Address <u>Ilm 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>			
420.1 DUE TO (b) <u>Hypertension</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/11/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEMETERY</u>		22d. LOCATION (City, town, or country) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR <u>WARNER E. PIMPHREY, INC.</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>Arthur L. Kraus</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	
DATE <u>JUN 14 '60</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 17 Film G265 6-24-60 et

7186

CERTIFICATE OF DEATH

02165

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6211 Kennedy Drive		d. STREET ADDRESS 6211 Kennedy Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Crete Last Willis		4. DATE OF DEATH Month June Day 22 Year 19 60	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/6/84
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Elmira, N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew McConnell		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. ----	
INFORMANT John C. Willis		5826 Oscadia Rd., High Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral emboli DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arterio Sclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4-5 days 4-5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Hemorrhage 7 years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 6, 1944 , to June 22, 1960 , that I last saw the deceased alive on June 21, 1960 , and that death occurred at 3:25 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE W.B. Wardrop MD		ADDRESS (Street, city or town, state) 800 Pershing Drive Silver Spring Md	
DATE SIGNED 6/22/60			
PHYSICIAN'S NAME (Type) W.B. WARDROP MD		800 PERSHING DRIVE SILVER SPRING MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 6/24/60	
22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. Washington 9, D.C.		24a. REC'D BY REGISTRAR JUN 22 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

02120

DEPT. OF HEALTH

1180

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7187

CERTIFICATE OF DEATH

07167

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE -- b. COUNTY --	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, DC	
d. NAME OF HOSPITAL OR INSTITUTION 9200 Wisconsin Avenue Congressional Manor Sanitarium		d. STREET ADDRESS 3823 Veazey Street N.W.	
3. NAME OF DECEASED (Type or print) First Lola Middle E Last Wood		4. DATE OF DEATH Month June Day 24 Year 1960	
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/5/1885
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Boarman		14. MOTHER'S MAIDEN NAME Unobtainable	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. no	
17. INFORMANT George E. Wood - Same #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemiplegia, right, acute DUE TO 334X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension moderately severe DUE TO Arteriosclerosis, general, advanced (c) Diabetes Mellitis, moderate		INTERVAL BETWEEN ONSET AND DEATH 5 days 3 yrs + 5 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitis, moderate		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4:10 P.M. 1957 to June 24, 1960 , that (I) (we) last saw the deceased alive on June 24, 1960 , and that death occurred at 8:55 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Stewart Crapp		22b. DATE SIGNED 6/24/60	
22c. PHYSICIAN'S NAME (Type) Stewart Crapp M.D.		22d. ADDRESS 3921 Ingomar St N.W. Wash 15 D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/27/60	
23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co. - 2901 14th St. N.W. Washington, D.C.		25. REC'D BY REGISTRAR June 27 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

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RECEIVED

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07168

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Frederick</u> ✓	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pooksville RFD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> 1011-2	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Pat. R., Edward Ferry</u>		d. STREET ADDRESS <u>*67 65 S. Market St.</u>	
3. NAME OF DECEASED (Type or print) <u>Daniel Allen Woods</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>male</u>		4. DATE OF DEATH <u>June 5 1960</u>	
6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>Jan 16 - 1950</u>		9. AGE (In years less birthday) <u>10</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel C Woods</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy Springs</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Police Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>850 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>drowning</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fishing in Pat R. 6-1-60 when motor boat upset</u>	
20c. TIME OF INJURY Month, Day, Year <u>6:30 p.m. 6-1-1960</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Pat R. R.</u>		20f. (City or town) <u>Knotville Falls - Fred. md</u> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Bruschant</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Bruschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 7, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		22d. LOCATION (City, town, or country) <u>Frederick, Maryland</u> (State)	
23. FUNERAL DIRECTOR <u>M. R. Etchison & Son, Frederick, Maryland</u>		24a. REC'D BY REGISTRAR <u>JUN 10 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

4457

7189

CERTIFICATE OF DEATH

Reg. 057169

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FAIRLAND				c. LENGTH OF STAY IN 1b 10/27/59-6/26/60		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FAIRLAND-NURSING Home				d. STREET ADDRESS 5026-7 1/2th W.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) LOUIS First WORONOW Middle W Last			4. DATE OF DEATH Month 6 Day 26 Year 1960				
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 14, 1884		9. AGE (In years lost birthday) 85 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		INFORMANT FANNIE WORONOW		Address 5026-7-N.W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus							INTERVAL BETWEEN ONSET AND DEATH Unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June , 19 38 to June 26, 1960 that I last saw the deceased alive on June 12, 1960 , and that death occurred at 2:45 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE B. P. Lefsky				DATE SIGNED 6/26/60			
PHYSICIAN'S NAME (Type) BENJAMIN P. LAESKY				ADDRESS (Street, city or town, state) 2025-Eye St NW Wash DC			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 6/28/60		22c. NAME OF CEMETERY OR CREMATORY ADAMS ISRAEL CEM		22d. LOCATION (City, town, or county) (State) DC	
23. FUNERAL DIRECTOR'S SIGNATURE Shelley - El Norton				ADDRESS 4217-92 Ave.		24a. REC'D BY REGISTRAR DATE JUN 28 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

02187

CERTIFICATE OF DEED

1888

[Faint, mostly illegible text, likely a deed or certificate, possibly containing names and dates.]

7190

CERTIFICATE OF DEATH

07170

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5013 Benton Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First REBECCA Middle WOSTEIN Last WOSTEIN		4. DATE OF DEATH Month June Day 9 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 16, 1888
9. AGE (In years last birthday) yrs. 72		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin Finkelstein		14. MOTHER'S MAIDEN NAME Gertrude —	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. INFORMANT Ben Wostein - Son - 1794 Verbena St., NW	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPOSTATIC PNEUMONIA DUE TO 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerosis DUE TO Diabetes (c) Diabetes		INTERVAL BETWEEN ONSET AND DEATH 4 days 10 yrs 20 "	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May , 19 60 , to June 9, 1960 , that I last saw the deceased alive on 6-8 , 19 60 , and that death occurred at 8:15 M, from the causes and on the date stated above. 6-9-60 ADDRESS (Street, city or town, state) 3701- Conn Ave NW Wash DC DATE SIGNED 6-9-60			
ACTUAL SIGNATURE Herbert L. Tanenbaum, M.D.		PHYSICIAN'S NAME (Type) Herbert L. Tanenbaum, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-10-60	22c. NAME OF CEMETERY OR CREMATORY Hebrew Mt. Carmel Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE B. panzansky & Sons - 3501 14th St., NW		24a. REC'D BY REGISTRAR DATE JUN 13 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1951

CERTIFICATE OF DEATH

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MONTGOMERY

MARYLAND

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07171

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY CO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAKE PARK		c. LENGTH OF STAY IN 1b 1 Hour 40	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JACOB Middle ZAWATSKY Last ZAWATSKY		4. DATE OF DEATH Month JUNE Day 25 Year 1960	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May-25-96
9. AGE (In years last birthday) 64 rs.		10. IF UNDER 1 YEAR Months 6 Days 4 Hours 4 Min.	11. IF UNDER 24 HRS. Months 6 Days 4 Hours 4 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUILDER		10b. KIND OF BUSINESS OR INDUSTRY HOME-BUILDER	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Abraham Zawatsky		14. MOTHER'S MAIDEN NAME Anna Wiggatoff	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 130-07-0875	
17. INFORMANT Mrs Pauline Zawatsky (wife)		18. ADDRESS 10106 GEORGIA AVE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO GENERALIZED ARTERIOSCLEROSIS (c) DIABETES MELLITUS		INTERVAL BETWEEN ONSET AND DEATH 6 HOURS 10 YEARS 15 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 1954 to 6/23/60 , that (I) (we) last saw the deceased alive on 6/23/60 , and that death occurred at 4:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE Samuel D. Loube M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) SAMUEL D. LOUBE, M.D.		22d. ADDRESS 2025 EYE ST, N.W., WASHINGTON, D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/26/1960	
23c. NAME OF CEMETERY OR CREMATORY DETH SHOLOM Cem.		23d. LOCATION (City, town, or county) (State) CAP. HTS. MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Frederick J. ... ADDRESS 4217 9th Ave		25a. REC'D BY REGISTRAR DATE JUN 28 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. ...			

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CERTIFICATE OF DEATH

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CERTIFICATE OF DEATH

Reg. Dist. No. 07172

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Mt. Airy,				c. LENGTH OF STAY IN 1b 3 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Brown Church Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last George Melvin Zimmerman				4. DATE OF DEATH Month Day Year June 4 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 18, 1883		9. AGE (In years lost birthday) yrs. 77	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own farm		11. BIRTHPLACE (State or foreign country) Feagaville, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward J. Zimmerman				14. MOTHER'S MAIDEN NAME Amanda Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-30-4057		INFORMANT Address Martz E. Zimmerman, Germantown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atherosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 10 years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 30, 19 60 to June 4, 19 60 that I last saw the deceased alive on May 30, 19 60 , and that death occurred at 4:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Damascus, Md. DATE SIGNED 6/5/60 ACTUAL SIGNATURE James P. Kerr M.D. Damascus, Md. PHYSICIAN'S NAME (Type) James P. Kerr							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 6, 1960		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		22d. LOCATION (City, town, or county) (State) Frederick, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Wolsunth				ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR DATE JUN 8 '60	
				24b. REGISTRAR'S SIGNATURE Charles L. Fennell			

TO HO...AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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